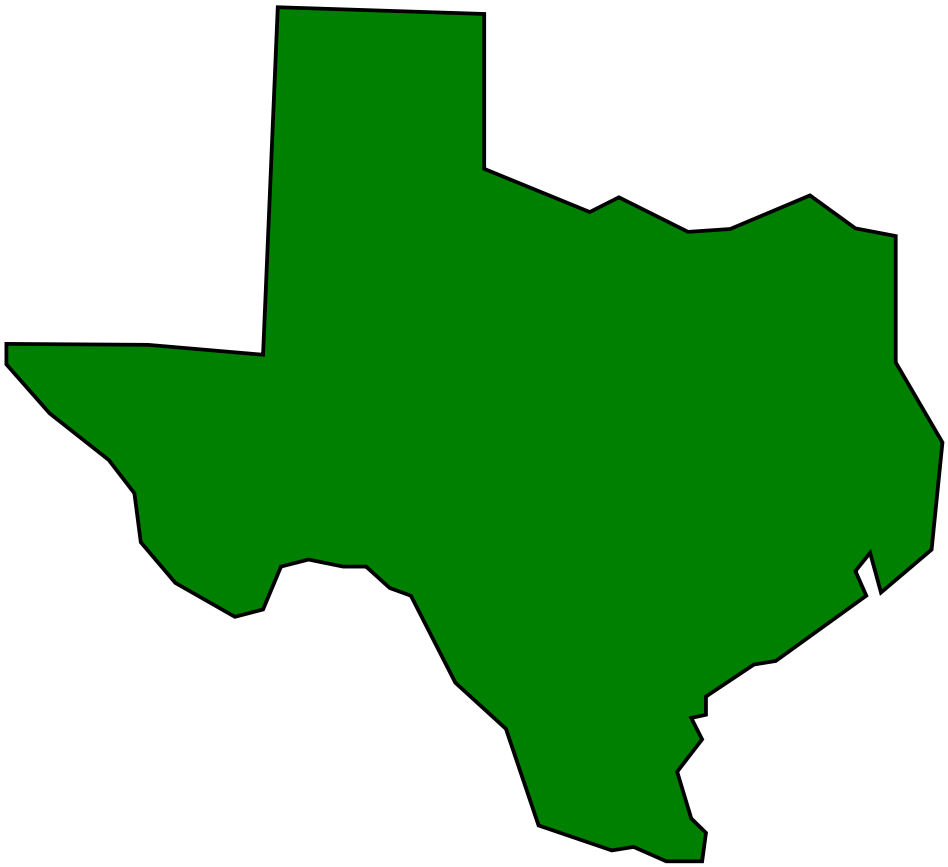
N H I C

NATIONAL HERITAGE INSURANCE COMPANY

TEXAS MEDICAID



TDH

PROVIDER RE-ENROLLMENT APPLICATION

N H I C

NATIONAL HERITAGE INSURANCE COMPANY

TEXAS MEDICAID

Application Table of Contents

Texas Medicaid Identification Form

Please check only the appropriate boxes to ensure proper re-enrollment. For assistance in choosing the appropriate provider type, please refer to Appendix A on pages 22-1 through 22-6.

Traditional Services

- ☐ •ADVANCED PRACTICE NURSE (APN)
- ☐ *AMBULANCE/AIR AMBULANCE
- ☐ *AMBULATORY SURGICAL CENTER (ASC)
- ☐ *AUDIOLOGIST
- ☐ BIRTHING CENTER
- ☐ *CATHERIZATION LAB
- ☐ *CERT. NURSE MIDWIFE (CNM)
- ☐ *CERT. REG. NURSE ANESTHETIST (CRNA)
- ☐ CHEM. DEPENDENCY TRTMT FAC. (TCADA)
- ☐ *CHIROPRACTOR
- ☐ *COMMUNITY MENTAL HEALTH CTRS (CMHC)
- ☐ *COMP. HEALTH CENTERS (CHC)
- ☐ *COMP. OUTPATIENT REHAB. FAC. (CORF)
- ☐ DIETICIAN
- ☐ *DENTAL
- ☐ #DURABLE MEDICAL EQPT (DME)
- ☐ DURABLE MEDICAL EQPT/HOME HEALTH
- ☐ FAMILY PLANNING AGENCY
- ☐ *FEDERALLY QUAL. HEALTH CTRS (FQHC)
- ☐ *FEDERALLY QUAL. LOOKALIKE (FQL)
- ☐ *FEDERALLY QUAL. SATELLITES (FQS)
- ☐ *FREESTANDING PSYCHIATRIC FAC.
- ☐ *FREESTANDING REHAB FAC.
- ☐ GENETICS
- ☐ HEARING AID
- ☐ *HOME HEALTH
- ☐ *HOSPITAL-IN STATE
- ☐ HOSPITAL AMBULATORY SURG. CTR. (HASC)
- ☐ HOSPITAL-MILITARY
- ☐ *HOSPITAL-OUT OF STATE
- ☐ #HYPERALIMENTATION
- ☐ *INDEPENDENT LAB
- ☐ LICENSED PROF. COUNSELOR (LPC)
- ☐ LICENSED VOCATIONAL NURSE
- ☐ MATERNITY SERVICE CLINICS (MSC)
- ☐ •OCCUPATIONAL THERAPIST (OT)
- ☐ *OPTICIAN
- ☐ *OPTOMETRIST (OD)
- ☐ •PHYSICAL THERAPIST
- ☐ *PHYSICIAN (MD, DO) (OB/GYN & PEDIATRICIANS NOT REQUIRED TO HAVE A MEDICARE NUMBER)
- ☐ *PHYSIOLOGICAL LABS
- ☐ *PODIATRIST
- ☐ *PORTABLE X-RAY
- ☐ *PSYCHOLOGIST
- ☐ *RADIATION TRTMT CTRS
- ☐ *RADIOLOGICAL LAB
- ☐ REGISTERED NURSE
- ☐ *RENAL DIALYSIS FAC.
- ☐ RESPIRATORY CARE PRACTITIONERS
- ☐ *RURAL HLTH CLINIC-HOSP., FREESTANDING
- ☐ *SKILLED NURSING FAC.
- ☐ •SOCIAL WORKER (LMSW-ACP)
- ☐ SPEECH THERAPIST
- ☐ SHARS-SCHOOL-CO-OP OR SCHOOL DIST.
- ☐ SHARS-NON SCHOOL
- ☐ TB CLINIC
- ☐ #VISION MEDICAL SUPPLIER (VMS)
- ☐ MULTI-SPECIALTY GROUPS

Targeted Case Management Services

- ☐ EARLY CHILDHOOD INTERVENTION (ECI)
- ☐ MH CASE MGMT/MR CASE MGMT
- ☐ MH REHAB
- ☐ PREG. WOMEN & INFANTS/HIGH RISK/TRGTD CASE MANAGEMENT (PWI)
- ☐ TEXAS COMMISSION FOR THE BLIND
- ☐ WOMEN, INFANT & CHILDREN (WIC) (IMMUNIZATION ONLY)

Chronically Ill and Disabled Children Services Program (CIDC) **

- ☐ ## PHYSICIAN
- ☐ ## FREESTANDING SURGICAL CENTER
- ☐ ## AMBULATORY SURGICAL CENTER (ASC)
- ☐ ## INDEPENDENT LAB
- ☐ ## HOSPITAL
- ☐ ## DENTAL

Comprehensive Care Services (CCP)

- ☐ DIETITIAN
- ☐ LICENSED VOCATIONAL NURSE (LVN)
- ☐ OCCUPATIONAL THERAPIST (OT)
- ☐ PHARMACY
- ☐ PHYSICAL THERAPIST (PT)
- ☐ REGISTERED NURSE (RN)
- ☐ SOCIAL WORKER (LMSW-ACP)
- ☐ SPEECH THERAPIST (SLP)

Texas Health Steps (THSteps) Services
Early and Periodic Screening, Diagnosis and Treatment (EPSDT)

☐ DENTAL ☐ MEDICAL ☐ MEDICAL CASE MGMT ☐ IMMUNIZATION SERVICES

Legend:
- • = Medicare number may be assigned but not required.
- # = Palmetto.
- * = Medicare number required.
- * * = Refer to your CIDC provider agreement for terms and conditions of enrollment.
- # # = Medicaid enrollment required.

Required Forms for Medicaid Re-enrollment

To avoid any delay of enrollment process, use this sheet as a checklist.

Required attachments supplied by provider of services if applicable:
The following requested attachments must be returned with application for processing:

- ___ Copy of License/Temporary License
- ___ CLIA Certificate
- ___ Copy of Certification of Mammography Systems certificate for all providers rendering mammography services
- ___ Dental Specialty Form - dental providers only (p. 16)
- ___ Medicaid Audit Information - facilities only (p. 15)
- ___ Contact TexMedNet for ECS at 1-888-863-3638

☐ **Nonincorporated:**
The following forms must be completed and returned for processing:

- ___ Provider Re-enrollment Application (pp. 7-1 through 7-3)
- ___ TDH Texas Medical Assistance (Medicaid) Provider Agreement (pp. 8-1 through 8-9)
- ___ Provider Information Form – MUST BE NOTARIZED – I.A. or I.C. and I.D.
- ___ Disclosure of Ownership and Control Interest Statement (pp. 10 through 11-2)
- ___ IRS W9 Form (p. 12)

☐ **Incorporated:**
The following forms must be completed and returned for processing:

- ___ Provider Re-enrollment Application (pp. 7-1 through 7-3)
- ___ TDH Texas Medical Assistance (Medicaid) Provider Agreement (pp. 8-1 through 8-9)
- ___ Provider Information Form – MUST BE NOTARIZED – I.B. and I.D.
- ___ Disclosure of Ownership and Control Interest Statement (pp. 10 through 11-2)
- ___ IRS W9 Form (p. 12)
- ___ Corporate Board of Directors Resolution - MUST BE NOTARIZED (p. 14)
- ___ Certificate of Incorporation (see below) – Out-of-state providers exempt
- ___ Certificate of Good Standing (see below) – Out-of-state providers exempt

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Certification of Incorporation/Certificate of Authority:
This certificate is located in your corporation records or can be obtained from the Office of the Secretary of State. If your corporation is registered in a state other than Texas, a Certificate of Authority to do business in Texas is required. Send a copy of this document when you return the re-enrollment application.

Certificate of Good Standing:
This certificate must be obtained from the Texas State Comptroller's Office. It is a new requirement of H.B. 175. A certificate can be obtained by contacting:

State Comptroller's Office; Tax Assistance Section
Interstate WATS Telephone Number 1-800-252-5555
Austin Telephone Number 1-512-463-4600

There is no charge for this request. The request may be made by telephone, and the certificate will be mailed to the requester. Callers must have the taxpayer's name, identification number, and charter number available at the time of the request.

If your corporation has a **501C Internal Revenue Exemption**, this form is not required. Please indicate this by signing the appropriate box on "Disclosure of Ownership Form."

Useful Information

PLEASE READ

Filing Deadline Information

All claims for services rendered to Medicaid recipients who do not have Medicare benefits are subject to a filing deadline from date of service of:

- 95 days for IN-STATE providers.
- 365 days for OUT-OF-STATE providers

These deadlines are established by the Texas Department of Health (TDH).

All claims for services must be received by NHIC within this deadline regardless of the status of your enrollment. Therefore, National Heritage Insurance Company (NHIC) encourages providers to submit all claims for services that have been provided to Medicaid recipients to the following address within the 95-day filing deadline.

National Heritage Insurance Company
PO Box 200555
Austin TX 78720-0555

All claims for new providers are denied until a Medicaid provider number has been assigned. However, these denied claims can be reconsidered for payment on an appeals basis after the enrollment process is complete and a Medicaid provider number is assigned. The denial of your claims serves as documentation that your claims were initially filed within the 95-day filing deadline. Procedures for appealing denied claims are included on the Remittance and Status (R&S) Report and in the *Texas Medicaid Provider Procedures Manual.*

'Lock-In' (Limited) Information

Recipients potentially overutilizing the program are identified by TDH when their use of certain Medicaid services exceeds the utilization rate at the 90th percentile of all Medicaid recipients. Recipients qualifying for limited status are required to choose one physician whose specialty is general practice, family practice, or internal medicine. If a limited candidate does not choose a physician, one is chosen for the recipient by TDH after obtaining agreement from the physician. The physician is responsible for determining appropriate medical services and the frequency of such services. A referral by the designated physician is required if the patient is treated by other physicians.

Change Of Ownership (CHOW)

Under procedures set forth by the Health Care Finance Administration (HCFA) and TDH, a change in ownership of a facility does not terminate Medicare eligibility; therefore, Medicaid participation may be continued provided that the new owners comply with the following requirements:

1. Obtain recertification as a Title XVIII (Medicare) facility under the new ownership.
2. Complete new Medicaid provider enrollment packet.
3. Provide NHIC with copy of the Contract of Sale (specifically, a signed agreement that includes the identification of previous and current owners).

Give a listing of ALL provider numbers effected by the change in ownership.

Written Communication

Enrollment Applications:
National Heritage Insurance Company
Attn: Provider Enrollment
11044 Research Blvd., Bldg. C
Austin TX 78759-5239

Claims:
National Heritage Insurance Company
PO Box 200555
Austin TX 78720-0555

Telephone Communication

CCP Customer Service	1-800-846-7470
Customer Inquiry	1-800-925-9126
TexMedNet	1-888-863-3638

Frequently Asked Re-enrollment Questions

Q. **Can I fax my applications for processing?**
A. No. Applications must contain original, not copied signatures.

Q. **Should I send my application via express or certified mail?**
A. Because of the tremendous amount of incoming mail, sending applications through express or certified mail helps to ensure receipt of the information, to locate information through tracking numbers, and guarantee quicker delivery.

Q. **As a Medicaid provider, how long am I required to retain records pertaining to services rendered?**
A. Records must be retained for a minimum of five (5) years [freestanding rural health clinics (RHCs) for six (6) years, hospital-based RHCs for ten (10) years] from the date of service or until all audit questions, appeal hearings, investigations, or court cases are resolved.

Q. **Should I include my CIDC provider number on the re-enrollment application?**
A. Yes. You should include all provider numbers that have the same information, including Medicaid and CIDC provider numbers on page 7-1.

Q. **Can I fill out one re-enrollment packet for all of my numbers?**
A. Yes. You should fill out one packet for all provider numbers that have the same information (for example, same physical and accounting addresses, same Tax ID or License number, same telephone number, and same name). When completing the information, if there are differences in the information that would be reported for two different provider numbers, two different packets must be completed.

Q. **Does the Provider Agreement on page 8-1 replace the CIDC provider agreement I have already signed?**
A. No. The Medicaid Provider agreement (pp. 8-1 through 8-9) does not replace the CIDC Provider Agreement signed upon enrollment into the CIDC Program. For all terms and conditions of participation in the CIDC program, refer to your CIDC Provider Agreement.

Q. **Will my Medicaid managed care numbers or my CIDC provider numbers be disenrolled if my Medicaid re-enrollment is not completed?**
A. Yes.

Q. **Why do I have to complete redundant information on multiple forms in the packet?**
A. Consolidating the forms to eliminate redundancy would actually increase the amount of paperwork for a large portion of providers (individuals performing in a group). Every effort has been made to eliminate and minimize duplicate information.

Q. **Will these forms be available electronically?**
A. Yes, at a minimum, the provider application, agreement, and information form will be posted on the TexMedNet Bulletin Board System (BBS).

All Forms in These Sections Must Be Completed By All Providers

Original Signatures Are Required On The Following:

* Must Be Notarized

NOTE: Please retain a copy of all documents for your records.

TEXAS MEDICAID PROVIDER RE-ENROLLMENT APPLICATION

- **All information must be completed or marked "N/A" and contain a valid signature to be processed**
- **Original signatures only, copies or stamped signatures are not accepted**
- **Please use blue ink**

ALL APPLICANTS MUST FILL OUT ACCORDINGLY

PLEASE CHECK APPLICABLE BOX

APPLICANT ENROLLED AS: ☐ Individual ☐ Group ☐ Facility

APPLICANT ENROLLED INTO PROGRAM TYPE: ☐ Texas Medicaid ☐ CIDC and Texas Medicaid

Section A PROVIDER OF SERVICE INFORMATION

Existing Texas Medicaid Provider Numbers

Please list all other assigned Texas Medicaid provider numbers in boxes to right:

Do you want to be a limited provider? See Pg. 4 ☐ Yes ☐ No

Group/Company or Last Name | First | Initial | Title/Degree

(Copy of License /Temporary License Required)

( ) - - -

Telephone Number | Social Security Number (For individual enrollment only) | License No. | Issue Date

Medicare Intermediary | Medicare Number | Medicare Certification Date

Primary Specialty:

Sub-Specialty:

Employer's Tax ID Number | Legal Name According To The IRS (Identical to W9) | Specialty of Practice

Number | Street | Room/Suite | City | State | Zip
(Physical Address - Where notification and provider information is to be sent)

Number | Street | Room/Suite | City | State | Zip
(Accounting Address - If different from above)

Group Medicare Number: _____ **Or group nine-digit Texas Medicaid provider number:** _____

Answer these questions to determine Facility Type:

PLEASE CHECK APPROPRIATELY	Yes	No	N/A
Is this a freestanding facility?			
Note: Freestanding RHCs must attach a copy of encounter rate letter from Medicare			
Is this a hospital-based facility ?			
Is this an ESRD facility?			
If Yes, what is your current composite rate? _____			

Case Management High Risk PWI Providers Only: You must attach a copy of your approval letter from TDH	Yes	No	N/A
Are you a public entity?			
Are you a private entity?			
Name and address of person certifying expended funds:			

Section A Continued PROVIDER OF SERVICE INFORMATION

Early Childhood Intervention (ECI) Providers Only: You must attach a copy of your approval letter from the Interagency Council on Early Childhood Intervention	Yes	No	N/A
Are you a public entity?			
Are you a private entity?			
Are you applying for case management?			
Name and address of person certifying expended funds:			

Hearing (Aid) Providers Only:	Yes	No	N/A
Are you a physician?			
Are you a fitter/dispenser?			
Are you an audiologist?			
Will you be conducting evaluations?			
Will you be dispensing hearing aids?			

Hospital Providers Only:	Yes	No	N/A
Are you a public entity?			
Are you a private entity?			
Is this a hospital facility?			
If hospital, what is your daily average room rate? Private: $_____ Semi-Private: $_____			

School Health And Related Services (SHARS) Providers Only:	Yes	No	N/A
Are you enrolling as a school district?			
If Yes, give school six-digit T.E.A. Number:_____			
Are you enrolling as special education co-op?			
If enrolling as a special education co-op, attach a list of all school districts in the co-op that will be providing SHARS services. Please include complete addresses and School District Number of each school district and its T.E.A. Number			
If Yes, give Fiscal Agent Number:_____			
Name and address of person certifying expended funds:			

Section B GROUP PRACTICE - Individual performing provider's part of a group to be added

Group Medicare Number: _____ **Or group nine-digit Texas Medicaid provider number:** _____

Name	License Number	License Issue Date	Social Security No.	Medicare No.	Title/Degree

Section C — REQUIRED INFORMATION FOR:

All Licensed Providers:
Must attach a copy of license

Ambulance:
Must attach a copy of the permit/license from TDH

Birthing Center Providers Only:
Must attach a copy of the certification permit from TDH

Certified Registered Nurse Anesthetist Providers Only:
Must attach a copy of CMA certification or recertification card

Chemical Dependency Treatment Facility Providers Only:
Must attach a copy of TCADA license

CLIA Providers:
Must attach a copy of CLIA license with approved specialty services as appropriate

FQHC Providers Only:
Must attach a list of contracted providers and names and addresses of your satellite centers that have been approved by the Public Health Service and a copy of grant award

Mammography Services Only:
Certification Number: _____

Must attach a copy of certification of mammography systems from the Texas Department of Bureau of Radiation Control (BRC)

MHMR Providers Only:
Must attach a copy of approval letter from the Texas Department of MHMR

To the best of my knowledge, the information supplied on this document is accurate and complete and is hereby released to National Heritage Insurance Company and Texas Department of Health for the purpose of issuing a Medicaid provider number.

Signature of applicant
(or an authorized representative if you are enrolling as a provider group/supplier)

_____
Signature

_____
Title Date

Do Not Write In This Area
(For Office Use Only)

#_____

Date:_____

Initials:_____

Notification of your assigned Texas Medicaid provider number will be mailed to the **PHYSICAL** address listed on your application.

TEXAS DEPARTMENT OF HEALTH (TDH) - TEXAS MEDICAL ASSISTANCE PROGRAM (MEDICAID) PROVIDER AGREEMENT

Name of Provider _____ *Medicaid Provider I.D. # _____

(Doing Business As) _____ Medicare Provider I.D. # _____

Physical Address _____ Mailing Address _____

_____ _____

As a condition for participation as a provider under the Texas Medical Assistance Program (Medicaid), the provider (Provider) agrees to comply with all terms and conditions of this Agreement.

I. ALL PROVIDERS

1.1 Agreement and documents constituting Agreement.

A copy of the current *Texas Medicaid Provider Procedures Manual* (Provider Manual) has been or will be furnished to the Provider. The Provider Manual, all revisions made to the Provider Manual through the bimonthly update entitled *Texas Medicaid Bulletin*, and written notices are incorporated into this Agreement by reference. Provider has a duty to become familiar with the contents and procedures contained in the Provider Manual. Provider agrees to comply with all of the requirements of the Provider Manual, as well as all state and federal laws and amendments, governing or regulating Medicaid. Provider is responsible for ensuring that employees or agents acting on behalf of the Provider comply with all of the requirements of the Provider Manual and all state and federal laws and amendments governing and regulating Medicaid.

1.2 State and Federal regulatory requirements.

1.2.1 Provider has not been excluded or debarred from participation in any program under Title XVIII (Medicare) or any program under Title XIX (Medicaid) under any of the provisions of Section 1128(A) or (B) of the Social Security Act (42 U.S.C. §1320a-7), or Executive Order 12549. Provider also has not been excluded or debarred from participation in any other state or federal health-care program. Provider must notify TDH or its agent within ten (10) business days of the time it receives notice that any action is being taken against Provider or any person defined under the provisions of Section 1128(A) or (B), which could result in exclusion from the Medicaid program. Provider agrees to comply with 45 C.F.R. Part 76, "Governmentwide Debarment and

*Please list additional provider numbers on the Addendum Statement for this Agreement. New applicants should leave this space blank.

Suspension (Nonprocurement) and Governmentwide Requirements for Drug-Free Workplace (Grants)." This regulation requires the Provider, in part, to: (a) execute the attached "Certification Regarding Debarment, Suspension, Ineligibility and Voluntary Exclusion-Lower Tier Covered Transactions" (Attachment I) upon execution of this Agreement; (b) provide written notice to TDH or its agent if at any time the Provider learns that its certification was erroneous when submitted or has become erroneous by reason of changed circumstances; and (c) require compliance with 45 C.F.R. Part 76 by participants in lower tier covered transactions.

1.2.2 Provider agrees to disclose information on ownership and control, information related to business transactions, and information on persons convicted of crimes in accordance with 42 C.F.R. Part 455, Subpart B, and provide such information on request to TDH, the Texas Health and Human Services Commission, the Texas Department of Human Services, the Texas Attorney General's Medicaid Fraud Control Unit, and/or the United States Department of Health and Human Services. Provider agrees to keep its application for participation in the Medicaid program current by informing TDH or its agent in writing of any changes to the information contained in its application, including, but not limited to, changes in ownership or control, federal tax identification number, or provider business addresses, at least ten (10) business days prior to making such changes. Provider also agrees to notify TDH or its agent within ten (10) business days of any restriction placed on or suspension of the Provider's license or certificate to provide medical services, and Provider must provide to TDH complete information related to any such suspension or restriction.

1.2.3 This Agreement is subject to all state and federal laws and regulations relating to fraud and abuse in health care and the Medicaid program. As required by 42 C.F.R. §431.107, Provider agrees to keep any and all records necessary to disclose the extent of services provided by the Provider to individuals in the Medicaid program and any information relating to payments claimed by the Provider for furnishing Medicaid services. Provider also agrees to provide, on request, access to records required to be maintained under 42 C.F.R. §431.107 and copies of those records free of charge to TDH, TDH's agent, the Texas Health and Human Services Commission, the Texas Attorney General's Medicaid Fraud Control Unit, and/or the United States Department of Health and Human Services. The records must be retained in the form in which they are regularly kept by the Provider for five (5) years from the date of service [six (6) years for freestanding rural health clinics]; or until all audit or audit exceptions are resolved, whichever period is longest. Provider must cooperate with and assist TDH and any state or federal agency charged with the duty of identifying, investigating, sanctioning, or prosecuting suspected fraud and abuse. Provider must also allow these agencies and/or their agents access to its premises.

1.2.4 The Texas Attorney General's Medicaid Fraud Control Unit, Texas Health and Human Services Commission's Office of Investigations and Enforcement, and internal and external auditors for the state/federal government and/or TDH may conduct interviews of Provider employees, subcontractors and their employees, witnesses, and recipients without the Provider's representative or Provider's legal counsel present unless the person voluntarily requests that the representative be present. Provider's employees, subcontractors and their employees, witnesses, and recipients must not be coerced by Provider or Provider's representative to accept representation by the Provider, and Provider agrees that no retaliation will occur to a person who denies the Provider's offer of representation. Nothing in this agreement limits a person's right to counsel of his or her choice. Requests for interviews are to be complied within the form and the manner requested. Provider will ensure by contract or other means that its employees and subcontractors over whom the Provider has control cooperate fully in any investigation conducted by the Texas Attorney General's Medicaid Fraud Control Unit and/or the Texas Health and Human Services Commission's Office of Investigations and Enforcement. Subcontractors are those persons or entities who provide medical goods or services for which the Provider bills the Medicaid program or who provide billing, administrative, or management services in connection with Medicaid-covered services.

1.2.5 Nondiscrimination. Provider must not exclude or deny aid, care, service or other benefits available under Medicaid or in any other way discriminate against a person because of that person's race, color, national origin, gender, age, disability, political or religious affiliation or belief. Provider must provide services to Medicaid recipients in the same manner, by the same methods, and at the same level and quality as provided to the general public.

1.2.6 AIDS and HIV. Provider must comply with the provisions of Texas Health and Safety Code Chapter 85, and TDH's rules relating to workplace and confidentiality guidelines regarding HIV and AIDS.

1.2.7 Child Support. (1) The Texas Family Code §231.006 requires TDH to withhold contract payments from any entity or individual who is at least thirty (30) days delinquent in child support obligations. It is the Provider's responsibility to determine and verify that no owner, partner, or shareholder who has at least 25% ownership interest is delinquent in any child support obligation. Provider must attach a list of the names, social security numbers, and medical license numbers if applicable, of all shareholders, partners, or owners who have at least a 25% ownership interest in the Provider. (2) Under Section 231.006 of the Family Code, the vendor or applicant certifies that the individual or business entity named in the applicable contract, bid, or application is not ineligible to receive the specified grant, loan, or payment and acknowledges that this Agreement may be terminated and payment may be withheld if this certification is inaccurate. A child support obligor who is more than thirty (30) days delinquent in paying child support or a business entity in which the obligor is a sole proprietor, partner, shareholder, or owner with an ownership interest of at least 25% is not eligible to receive the specified grant, loan or payment. (3) If TDH is informed and verifies that a child support obligor who is more than thirty (30) days delinquent is a partner, shareholder, or owner with at least a 25% ownership interest, it will withhold any payments due under this Agreement until it has received satisfactory evidence that the obligation has been satisfied or that the obligor has properly entered into a written repayment agreement.

1.2.8 Cost Report, Audit, and Inspection. Provider agrees to comply with all state and federal laws relating to the preparation and filing of cost reports, audit requirements, and inspection and monitoring of facilities, quality, utilization, and records.

1.3 Claims and Encounter Data

1.3.1 Provider agrees to submit claims for payment in accordance with billing guidelines and procedures promulgated by TDH, or other appropriate payor, including electronic claims. Provider certifies that information submitted regarding claims or encounter data will be true and accurate, complete, and that such information can be verified by source documents from which data entry is made by the Provider. Further, Provider understands that any falsification or concealment of a material fact may be prosecuted under state and federal laws.

1.3.2 Provider must submit encounter data required by TDH or any managed care organization to document services provided, even if the Provider is paid under a capitated fee arrangement by an HMO or IPA.

1.3.3 All claims or encounters submitted by Provider must be for services actually rendered by Provider. Physician providers must submit claims for services rendered by another in accordance with TDH rules regarding providers practicing under physician supervision. Claims must be submitted in the manner and in the form set forth in the Provider Manual, and within the time limits established by TDH for submission of claims. Claims for payment or encounter data submitted by the provider to an HMO or IPA are governed by the Provider's contract with the HMO or IPA. Provider understands and agrees that TDH is not liable or responsible for payment for any Medicaid-covered services provided under the HMO or IPA Provider contract, or any agreement other than this Medicaid Provider Agreement. Federal and state laws provide severe penalties for any provider who attempts to collect any payment from or bill a recipient for a covered service.

1.3.4 Federal law prohibits Provider from charging a recipient or any financially responsible relative or representative of the recipient for Medicaid-covered services, except where a copayment is authorized under the Medicaid State Plan. (42 C.F.R. §447.20).

1.3.5 As a condition for eligibility for Medicaid benefits, a recipient assigns all rights to recover from any third party or any other source of payment to TDH (42 C.F.R. §433.145 and Human Resources Code §32.033). Except as provided by TDH's third-party recovery rules (25 TAC Chapter 28), Provider agrees to accept the amounts paid under Medicaid as payment in full for all covered services. (42 C.F.R. §447.15).

1.3.6 Provider must refund any overpayments, duplicate payments, and erroneous payments which are paid to Provider by Medicaid or a third party as soon as the payment error is discovered.

1.3.7 Provider has an affirmative duty to verify that claims and encounters are received by TDH or its agent and implement an effective method to track submitted claims against payments made by TDH.

1.3.8 TexMedNet and Electronic Claims Submission. Provider may subscribe to the TDH TexMedNet system, which allows the provider the ability to electronically submit claims, claims appeals, verify recipient eligibility, and receive electronic claims status inquiries, remittance and status reports, and transfer of funds into a provider account. Provider understands and acknowledges that independent registration is required to receive the electronic funds or electronic remittance report. Provider agrees to comply with the provisions of the Provider Manual and the TexMedNet licensing agreement regarding the transmission and receipt of electronic claims and eligibility verification data. Provider must verify that all claims submitted to TDH or its agent are received and accepted. Provider is responsible for tracking claims transmissions against claims payments and detecting and correcting all claims errors. If Provider contracts with third parties to provide claims and/or eligibility verification data from TDH, the Provider remains responsible for verifying and validating all transactions and claims, and ensuring that the third party adheres to all client data confidentiality requirements.

II. ADVANCE DIRECTIVES - HOSPITAL AND HOME HEALTH PROVIDERS

2.1 The recipient must be informed of their right to refuse, withhold, or have medical treatment withdrawn under the following state and federal laws:

2.1.1 the individual's right to self-determination in making health-care decisions;

2.1.2 the individual's rights under the Natural Death Act (Health and Safety Code, Chapter 672) to execute an advance written Directive to Physicians, or to make a nonwritten directive regarding their right to withhold or withdraw life sustaining procedures in the event of a terminal condition;

2.1.3 the individual's rights under Health and Safety Code, Chapter 674, relating to written Out-of-Hospital Do-Not-Resuscitate Orders; and,

2.1.4 the individual's rights to execute a Durable Power of Attorney for Health Care under the Civil Practice and Remedies Code, Chapter 135, regarding their right to appoint an agent to make medical treatment decisions on their behalf in the event of incapacity.

2.2 The Provider must have a policy regarding the implementation of the individual's rights and compliance with state and federal laws.

2.3 The Provider must document whether or not the individual has executed an advance directive and ensure that the document is in the individual's medical record.

2.4 The Provider cannot condition giving services or otherwise discriminate against an individual based on whether or not the recipient has or has not executed an advance directive.

2.5 The Provider must provide written information to all adult recipients on the provider's policies concerning the recipient's rights.

2.6 The Provider must provide education for staff and the community regarding advance directives.

III. STATE FUND CERTIFICATION REQUIREMENT FOR PUBLIC ENTITY PROVIDERS

3.1 Public providers are those that are owned or operated by a state, county, city, or other local government agency or instrumentality. Public entity providers of the following services are required to certify to TDH the amount of state matching funds expended for eligible services according to established TDH procedures:

school health and related services (SHARS)
case management for high risk pregnant women and infants (PWI)
case management for blind and visually impaired children (BVIC)
case management for early childhood intervention (ECI)
case management for mental retardation (MR)
case management for mental health (MH)
mental health rehabilitation (MHR)
tuberculosis clinics
state hospital physician

3.2 Public entity SHARS providers are also required to reimburse TDH, according to established TDH procedures, the nonfederal share of expenditures made by TDH for SHARS provided by Medicaid approved nonschool providers to children enrolled in their school district.

IV. RECIPIENT RIGHTS

4.1 Provider must maintain the recipient's state and federal right of privacy and confidentiality to the medical and personal information contained in Provider's records.

4.2 The recipient must have the right to choose providers unless that right has been restricted by TDH or by waiver of this requirement from HCFA. The recipient's acceptance of any service must be voluntary.

4.3 The recipient must have the right to choose any qualified provider of family planning services.

V. TERM AND TERMINATION

This Agreement will be effective from the date finally executed until the date the Agreement is terminated by either party. Either party may terminate this Agreement by providing the other party with thirty (30) days advance notice of intent to terminate. TDH may immediately terminate the Agreement for cause if the Provider is excluded from the Medicare or Medicaid programs for any reason, loses its licenses or certificate, becomes ineligible for participation in the Medicaid program, fails to comply with the provisions of this Agreement, or if the Provider is or may be placing the health and safety of recipients at risk. TDH may terminate this Agreement without notice if the Provider has not submitted a claim to the Medicaid program for 12 months.

Provider Signature _____ Date _____

Printed Name and Title of Person signing for Provider

_____

ADDENDUM STATEMENT

The numbers listed below are to be associated with the above-signed agreement, application, and provider information form. I understand that by signing this addendum I am reporting that these provider numbers are fully represented by the information contained in the enclosed documents and that all provisions included in the agreement are also applicable to these provider numbers. **List all provider numbers:**

Print Name Sign Name

Date_____

CERTIFICATION
REGARDING DEBARMENT, SUSPENSION, INELIGIBILITY AND VOLUNTARY EXCLUSION FOR COVERED CONTRACTS
Attachment I

Federal Executive Orders 12549 and 12689 require the Texas Health and Human Services Commission (HHSC) to screen each covered potential contractor to determine whether each has a right to obtain a contract in accordance with federal regulations on debarment, suspension, ineligibility, and voluntary exclusion. Each covered contractor must also screen each of its covered subcontractors.

In this certification "contractor" refers to both contractor and subcontractor; "contract" refers to both contract and subcontract.

By signing and submitting this certification the potential contractor accepts the following terms:

1. The certification herein below is a material representation of fact upon which reliance was placed when this contract was entered into. If it is later determined that the potential contractor knowingly rendered an erroneous certification, in addition to other remedies available to the federal government, the Department of Health and Human Services, United States Department of Agriculture or other federal department or agency, or the HHSC may pursue available remedies, including suspension and/or debarment.

2. The potential contractor will provide immediate written notice to the person to which this certification is submitted if at any time the potential contractor learns that the certification was erroneous when submitted or has become erroneous by reason of changed circumstances.

3. The words "covered contract", "debarred", "suspended", "ineligible", "participant", "person", "principal", "proposal", and "voluntarily excluded", as used in this certification have meanings based upon materials in the Definitions and Coverage sections of federal rules implementing Executive Order 12549. Usage is as defined in the attachment.

4. The potential contractor agrees by submitting this certification that, should the proposed covered contract be entered into, it will not knowingly enter into any subcontract with a person who is debarred, suspended, declared ineligible, or voluntarily excluded from participation in this covered transaction, unless authorized by the Department of Health and Human Services, United States Department of Agriculture or other federal department or agency, and/or the HHSC, as applicable.

Do you have or do you anticipate having subcontractors under this proposed contract? ☐ Yes ☐ No

5. The potential contractor further agrees by submitting this certification that it will include this certification titled "Certification Regarding Debarment, Suspension, Ineligibility, and Voluntary Exclusion for Covered Contracts" without modification, in all covered subcontracts and in solicitations for all covered subcontracts.

6. A contractor may rely upon a certification of a potential subcontractor that it is not debarred, suspended, ineligible, or voluntarily excluded from the covered contract, unless it knows that the certification is erroneous. A contractor must, at a minimum, obtain certifications from its covered subcontractors upon each subcontract's initiation and upon each renewal.

7. Nothing contained in all the foregoing will be construed to require establishment of a system of records in order to render in good faith the certification required by this certification document. The knowledge and information of a contractor is not required to exceed that which is normally possessed by a prudent person in the ordinary course of business dealings.

8. Except for contracts authorized under paragraph 4 of these terms, if a contractor in a covered contract knowingly enters into a covered subcontract with a person who is suspended, debarred, ineligible, or voluntarily excluded from participation in this transaction, in addition to other remedies available to the federal government, Department of Health and Human Services, United States Department of Agriculture, or other federal department or agency, as applicable, and/or the HHSC may pursue available remedies, including suspension and/or debarment.

CERTIFICATION REGARDING DEBARMENT, SUSPENSION, INELIGIBILITY AND VOLUNTARY EXCLUSION FOR COVERED CONTRACTS

Indicate in the appropriate box which statement applies to the covered potential contractor:

☐ The potential contractor certifies, by submission of this certification, that neither it nor its principals is presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded form participation in this contract by any federal department or agency or by the State of Texas.

☐ The potential contractor is unable to certify to one or more of the terms in this certification. In this instance, the potential contractor must attach an explanation for each of the above terms to which he is unable to make certification. Attach the explanation(s) to this certification.

Name of Potential Contractor	Vendor ID No. Or Social Security No.	HHSC Contract No. (if applicable)

	Printed Typed Name and Title of Authorized Representative
Signature of Authorized Representative Date	

CERTIFICATION
REGARDING DEBARMENT, SUSPENSION, INELIGIBILITY AND VOLUNTARY EXCLUSION FOR COVERED CONTRACTS
Attachment I

DEFINITIONS

Covered Contracts/Subcontract.

(1) Any nonprocurement transaction which involves federal funds (regardless of amount and including such arrangements as subgrant and are between HHSC or its agents and another entity.

(2) Any procurement contract for goods or services between a participant and a person, regardless of type, expected to equal or exceed the federal procurement small purchase threshold fixed at 10 U.S.C. 2304(g) and 41 U.S.C. 253(g) (currently $25,000) under a grant or subgrant.

(3) Any procurement contract for goods or services between a participant and a person under a covered grant, subgrant, contract or subcontract, regardless of amount, under which that person will have a critical influence on or substantive control over that covered transaction:
   a. Principal investigators.
   b. Providers of audit services required by the HHSC or federal funding source.
   c. Researchers.

Debarment. An action taken by a debarring official in accordance with 45 C.F.R. Part 76 (or comparable federal regulations) to exclude a person from participating in covered contracts. A person so excluded is "debarred".

Grant. An award of financial assistance, including cooperative agreements, in the form of money, or property in lieu of money, by the federal government to an eligible grantee.

Ineligible. Excluded from participation in federal nonprocurement programs pursuant to a determination of ineligibility under statutory, executive order, or regulatory authority, other than Executive Order 12549 and its agency implementing regulations; for example, excluded pursuant to the Davis-Bacon Act and its implement regulations, the equal employment opportunity acts and executive orders, or the environmental protection acts and executive orders. A person is ineligible where the determination of ineligibility affects such person's eligibility to participate in more than one covered transaction.

Participant. Any person who submits a proposal for, enters into, or reasonably may be expected to enter into a covered contract. This term also includes any person who acts on behalf of or is authorized to commit a participant in a covered contract as an agent or representative of another participant.

Person. Any individual, corporation, partnership, association, unit of government, or legal entity, however organized, except: foreign governments or foreign governmental entities, public international organizations, foreign government owned (in whole or in part) or controlled entities, and entities consisting wholly or partially of foreign governments or foreign governmental entities.

Principal. Officer, director, owner, partner, key employee, or other person within a participant with primary management or supervisory responsibilities; or a person who has a critical influence on or substantive control over a covered contract whether or not the person is employed by the participant. Persons who have a critical influence on or substantive control over a covered transaction are:
(1) Principal investigators.
(2) Providers of audit services required by the HHSC or federal funding source.
(3) Researchers.

Proposal. A solicited or unsolicited bid, application, request, invitation to consider or similar communication by or on behalf of a person seeking to receive a covered contract.

Suspension. An action taken by a suspending official in accordance with 45 C.F.R. Part 76 (or comparable federal regulations) that immediately excludes a person from participating in covered contracts for a temporary period, pending completion of an investigation and such legal, debarment, or Program Fraud Civil Remedies Act proceedings as may ensue. A person so excluded is "suspended".

Voluntary exclusion or voluntarily excluded. A status of nonparticipation or limited participation in covered transactions assumed by a person pursuant to the terms of a settlement.

PROVIDER INFORMATION FORM

I.A. All Groups, Partnerships, I.P.A.s, Individual Practitioners, and Noncorporate Entities including Associations must complete this form before enrollment in the Texas Medicaid Program.

Please complete one of these forms for each individual.

Name: _____ Doing Business As (DBA) Name:_____

Other Name: _____ (For additional names or addresses, please attach necessary pages)

Physical Address: Accounting Address:

_____ _____

_____ _____

_____ _____

_____ _____

If your accounting address is different than your physical address, please indicate your relationship to the Accounting Address:

❑ Billing Agent ❑ Management Company ❑ Employer ❑ Self ❑ Other (explain):

_____

_____

_____

License No. & Issuer: _____ License Issue Date: _____

Social Security No.: _____ Employer's Tax ID: _____

Specialty of Practice: _____ Medicare Intermediary: _____

Medicare Provider No.: _____ Medicare Effective Date: _____

Driver's License No. & Issuer: _____ Driver's License No. Expiration Date: _____

Date of Birth: _____ Sex: ❑ M ❑ F

Previous Physical Address: Previous Business Address:

_____ _____

_____ _____

_____ _____

_____ _____

List all physical locations where Medicaid services are rendered using noted provider number(s).

_____ _____

_____ _____

_____ _____

_____ _____

Do you plan on using a billing agent to submit your Medicaid claims? ❑ Yes ❑ No
If yes, provide the following information about the billing agent:
Billing agent name: _____
Address: _____
Tax ID No.: _____
Contact person name: _____
Telephone No.: ( ) -

List all Texas Medicaid provider numbers under which you have billed in the past 12 months:
(attach additional sheets if necessary)

_____
_____
_____

List all contractual relationships with medical entities and the provider numbers of those entities:
(attach additional sheets if necessary)

_____
_____
_____
_____

Have you ever been excluded, debarred, or sanctioned from any state or federal program? ❑ Yes ❑ No
If yes, please fully explain the details including dates, the state where the incident occurred, and any adverse action against your license: (attach additional sheets if necessary)

_____
_____
_____
_____

Is your license currently suspended or restricted? ❑ Yes ❑ No
If yes, please fully explain the details including dates, the state where the incident occurred, and any adverse action against your license: (attach additional sheets if necessary)

_____
_____
_____
_____

Have you ever been convicted of a crime: ❑ Yes ❑ No (excluding minor traffic citations)
(a) Conviction or Convicted - a judgment of conviction of deferred adjudication has been entered against a person by a state or federal court without regard to the pendency of an appeal or referral to any special post-conviction proceeding;
(b) A person has been found guilty by a federal, state, or local court;
(c) A person has entered a plea of guilty or nolo contendere that has been accepted by a federal, state, or local court; or
(d) A person has entered a first offender or other program and judgment of conviction has been withheld.
If yes, please fully explain the details including dates, the state where the incident occurred, and any adverse action against your license:

_____
_____
_____

Are you currently behind 30 days or more on your child support payments? ❑ Yes ❑ No
If yes, please provide details: (attach additional sheets if necessary)

_____
_____
_____

Laboratory - CLIA (Clinical Laboratory Improvement Act)

CLIA Certification No.* and approved specialty services:

_____
_____

*Please submit CLIA certificate.

Mammography Facility Certification

Texas Department of Health Bureau of Radiation Control Certification No.*: _____

*Please enclose a copy of your TDH BRC Certification.

PROVIDER INFORMATION FORM

Officers, Directors, and Corporate Owners Form

I.B. If you, the provider, are part of a corporation, please complete this information for each of the following individuals, including but not limited to: Directors of Clinics/Facilities, Directors of Management Companies, and for each corporation the following individuals: owners, officers, directors, and shareholders with at least 25% share.

Please complete one of these forms for each individual.

Name: _____ Doing Business As (DBA) Name:_____

Other Name: _____ (For additional names or addresses, please attach necessary pages)

Physical Address: Accounting Address:

_____ _____

_____ _____

_____ _____

_____ _____

If your accounting address is different than your physical address, please indicate your relationship to the Accounting Address:

❑ Billing Agent ❑ Management Company ❑ Employer ❑ Self ❑ Other (explain):

_____

_____

_____

License No. & Issuer: _____ License Issue Date: _____

Social Security No.: _____ Employer's Tax ID: _____

Specialty of Practice: _____ Medicare Intermediary: _____

Medicare Provider No.: _____ Medicare Effective Date: _____

Driver's License No. & Issuer: _____ Driver's License No. Expiration Date: _____

Date of Birth: _____ Sex: ❑ M ❑ F

Previous Physical Address: Previous Business Address:

_____ _____

_____ _____

_____ _____

_____ _____

List all physical locations where Medicaid services are rendered using noted provider number(s).

_____ _____

_____ _____

_____ _____

_____ _____

Do you plan on using a billing agent to submit your Medicaid claims? ❑ Yes ❑ No
If yes, provide the following information about the billing agent:
Billing agent name: _____
Address: _____
Tax ID No.: _____
Contact person name: _____
Telephone No.: ( ) -

List all Texas Medicaid provider numbers under which you have billed in the past 12 months:
(attach additional sheets if necessary)

_____
_____
_____

List all contractual relationships with medical entities and the provider numbers of those entities:
(attach additional sheets if necessary)

_____
_____
_____
_____

Have you ever been excluded, debarred, or sanctioned from any state or federal program? ❑ Yes ❑ No
If yes, please fully explain the details including dates, the state where the incident occurred, and any adverse action against your license: (attach additional sheets if necessary)

_____
_____
_____
_____

Is your license currently suspended or restricted? ❑ Yes ❑ No
If yes, please fully explain the details including dates, the state where the incident occurred, and any adverse action against your license: (attach additional sheets if necessary)

_____
_____
_____
_____

Have you ever been convicted of a crime: ❑ Yes ❑ No (excluding minor traffic citations)
(a) Conviction or Convicted - a judgment of conviction of deferred adjudication has been entered against a person by a state or federal court without regard to the pendency of an appeal or referral to any special post-conviction proceeding;
(b) A person has been found guilty by a federal, state, or local court;
(c) A person has entered a plea of guilty or nolo contendere that has been accepted by a federal, state, or local court; or
(d) A person has entered a first offender or other program and judgment of conviction has been withheld.
If yes, please fully explain the details including dates, the state where the incident occurred, and any adverse action against your license:

_____
_____
_____

Are you currently behind 30 days or more on your child support payments? ❑ Yes ❑ No
If yes, please provide details: (attach additional sheets if necessary)

_____
_____
_____

Laboratory - CLIA (Clinical Laboratory Improvement Act)

CLIA Certification No.* and approved specialty services:

_____
_____

*Please submit CLIA certificate.

Mammography Facility Certification

Texas Department of Health Bureau of Radiation Control Certification No.*: _____

*Please enclose a copy of your TDH BRC Certification.

PROVIDER INFORMATION FORM

I.C. All Other Providers (not covered by I.A. or I.B.).

Please complete one of these forms for each individual.

Name: _____ Doing Business As (DBA) Name:_____

Other Name: _____ (For additional names or addresses, please attach necessary pages)

Physical Address: Accounting Address:

_____ _____

_____ _____

_____ _____

_____ _____

If your accounting address is different than your physical address, please indicate your relationship to the Accounting Address:

❑ Billing Agent ❑ Management Company ❑ Employer ❑ Self ❑ Other (explain):

_____

_____

_____

License No. & Issuer: _____ License Issue Date: _____

Social Security No.: _____ Employer's Tax ID: _____

Specialty of Practice: _____ Medicare Intermediary: _____

Medicare Provider No.: _____ Medicare Effective Date: _____

Driver's License No. & Issuer: _____ Driver's License No. Expiration Date: _____

Date of Birth: _____ Sex: ❑ M ❑ F

Previous Physical Address: Previous Business Address:

_____ _____

_____ _____

_____ _____

_____ _____

List all physical locations where Medicaid services are rendered using noted provider number(s).

_____ _____

_____ _____

_____ _____

_____ _____

Do you plan on using a billing agent to submit your Medicaid claims? ❑ Yes ❑ No
If yes, provide the following information about the billing agent:
Billing agent name: _____
Address: _____
Tax ID No.: _____
Contact person name: _____
Telephone No.: ( ) -

List all Texas Medicaid provider numbers under which you have billed in the past 12 months:
(attach additional sheets if necessary)

_____
_____
_____

List all contractual relationships with medical entities and the provider numbers of those entities:
(attach additional sheets if necessary)

_____
_____
_____
_____

Have you ever been excluded, debarred, or sanctioned from any state or federal program? ❑ Yes ❑ No
If yes, please fully explain the details including dates, the state where the incident occurred, and any adverse action against your license: (attach additional sheets if necessary)

_____
_____
_____
_____

Is your license currently suspended or restricted? ❑ Yes ❑ No
If yes, please fully explain the details including dates, the state where the incident occurred, and any adverse action against your license: (attach additional sheets if necessary)

_____
_____
_____
_____

Have you ever been convicted of a crime: ❑ Yes ❑ No (excluding minor traffic citations)
(a) Conviction or Convicted - a judgment of conviction of deferred adjudication has been entered against a person by a state or federal court without regard to the pendency of an appeal or referral to any special post-conviction proceeding;
(b) A person has been found guilty by a federal, state, or local court;
(c) A person has entered a plea of guilty or nolo contendere that has been accepted by a federal, state, or local court; or
(d) A person has entered a first offender or other program and judgment of conviction has been withheld.
If yes, please fully explain the details including dates, the state where the incident occurred, and any adverse action against your license:

_____
_____
_____

Are you currently behind 30 days or more on your child support payments? ❑ Yes ❑ No
If yes, please provide details: (attach additional sheets if necessary)

_____
_____
_____

Laboratory - CLIA (Clinical Laboratory Improvement Act)

CLIA Certification No.* and approved specialty services:

_____
_____

*Please submit CLIA certificate.

Mammography Facility Certification

Texas Department of Health Bureau of Radiation Control Certification No.*: _____

*Please enclose a copy of your TDH BRC Certification.

I.D. THIS SECTION MUST BE COMPLETED, SIGNED, AND NOTARIZED BY ALL PROVIDERS.

I certify that the above constitutes true and correct information. I agree to inform TDH or its designee, in writing, of any changes, or if additional information becomes available.

_____ _____

Signature of Provider Print name of Provider

Subscribed and Sworn before me, _____ a Notary Public for the State of _____, on the _____ day of _____, 19_____.

_____ State of _____

Signature of Notary Public

Notary seal or stamp

Reminder: This form must have original signatures and be notarized before returning to NHIC.

Instructions For Completing Disclosure Of Ownership And Control Interest Statement

Completion and submission of this form is a condition of participation, certification or recertification under any of the programs established by Titles V, XVIII, XIX and XX or as a condition of approval or renewal of a contractor agreement between the disclosing entity and the secretary of appropriate state agency under any of the above-titled programs, a full and accurate disclosure of ownership and financial interest is required. Failure to submit requested information may result in a refusal by the Secretary or appropriate State agency to enter into an agreement or contract with any such institution in termination of existing agreements.

GENERAL INSTRUCTIONS
Please answer all questions as of the current date. If the yes block for any item is checked, list requested additional information under the Remarks Section on page 2, referencing the item number to be continued. If additional space is needed, use an attached sheet.

DETAILED INSTRUCTIONS
These instructions are designed to clarify certain questions on the form. Instructions are listed in order of question for easy reference. NO instructions have been given for questions considered self-explanatory.

IT IS ESSENTIAL THAT ALL APPLICABLE QUESTIONS BE ANSWERED ACCURATELY AND THAT ALL INFORMATION BE CURRENT.

ITEM I (a) Under identifying information specify in what capacity the entity is doing business as (DBA), example, name of trade or corporation.

(b) **For Regional Office Use Only.** If the yes box is checked for item VII the Regional Office will enter the 5-digit number assigned by HCFA to chain organizations.

ITEM II - Self-explanatory.

ITEM III List the names of all individuals and organizations having direct or indirect ownership interests, or controlling interest separately or in combination amounting to an ownership interest of 5 percent or more in the disclosing entity.

Direct ownership interest is defined as the possession of stock, equity in capital or any interest in the profits of the disclosing entity. A disclosing entity is defined as a Medicare provider or supplier or other entity that furnishes services or arranges for furnishing services under Medicaid or the Maternal and Child Health program or health related services under the social services program.

Indirect ownership interest is defined as ownership interest in an entity that has direct or indirect ownership interest in the disclosing entity. The amount of indirect ownership in the disclosing entity that is held by any other entity is determined by multiplying the percentage of ownership interest at each level. An indirect ownership interest must be reported if it equates to an ownership interest of 5 percent or more in the disclosing entity. Example: if "A" owns 10 percent of the stock in a corporation that owns 80 percent of the stock of the disclosing entity, "A's" interest equates to an 8 percent indirect ownership and must be reported.

Controlling interest is defined as the operational direction or management of a disclosing entity which may be maintained by any or all of the following devices; the ability or authority, expressed or reserved to amend or change the corporate identity (i.e., joint venture agreement, unincorporated business status) of the disclosing entity; the ability or authority to nominate or name members of the Board of Directors or Trustees of the disclosing entity; the ability or authority, expressed or reserved to amend or change the by-laws, constitution or other operating or management direction of the disclosing entity; the right to control any or all of the assets or other property of the disclosing entity upon the sale or dissolution of that entity; the ability or authority, expressed or reserved to control the sale of any or all of the assets to encumber such assets by way of mortgage or other indebtedness, to dissolve the entity or to arrange for the sale or transfer of the disclosing entity to new ownership or control.

ITEMS IV through VII - Changes in Provider Status
Change in provider status is defined as any change in management control. Examples of such changes would include; a change in Medical or Nursing Director, a new Administrator, contracting the operation of the facility to a management corporation, a change in the composition of the owning partnership which under applicable State law is not considered a change in ownership, or the hiring or dismissing of any employees with 5 percent or more financial interest in the facility or in an owning corporation, or any change of ownership.
For items IV through VII, if the yes box is checked, list additional information requested under Remarks. Clearly identify which item is being continued.

ITEM IV - (a & b) If there has been a change in ownership within the last year or if you anticipate a change, indicate the date in the appropriate space.

ITEM V - If the answer is yes, list name or the management firm and employer identification number (EIN) or the leasing organization. A management company is defined as any organization that operates and names a business on behalf of the owner of that business with the owner retaining ultimate legal responsibility for operation of the facility.

ITEM VI - If the answer is yes, identify which has changed (Administrator, Medical Director or Director or nursing) and the date the change was made. Be sure to include name of the new administrator, Director of Nursing or Medical Director, as appropriate.

ITEM VII - A chain affiliate is any freestanding health care facility that is either owned, controlled or operated under lease or contract by an organization consisting of two or more freestanding health care facilities organized within or across State lines which is under the ownership or through any other device, control and direction of a common party. Chain affiliates include such facilities whether public, private, charitable or proprietary. They also include subsidiary organizations and holding corporations. Provider-based facilities such as hospital-based home health agencies are not considered to be chain affiliates.

ITEM VIII - If yes, list the actual number of beds in the facility now and the previous number.

This form similar to HCFA - 11513

Disclosure Of Ownership And Control Interest Statement

I. Identifying Information

(a) Name of Entity	D/B/A	Telephone No.		
Street Address		City, County	State	Zip Code

(b) (To be completed by HCFA Regional Office) Chain Affiliate No.

II. Answer the following questions by checking "Yes" or "No". If any of the questions are answered "Yes", list names and addresses of individuals or corporations under Remarks on page 11-2. Identify each item number to be continued.

(a). Are there any individuals or organizations having a direct or indirect ownership or control interest of 5 percent or more in the institution, organizations, or agency that have been convicted of a criminal offense related to the involvement of such persons, or organizations in any of the programs established by Titles XVIII, XIX, or XX? ☐ Yes ☐ No

(b) Are there any directors, officers, agents, or managing employees of the institution, agency or organization who have ever been convicted of a criminal offense related to their involvement in such programs established by Titles XVIII, XIX, or XX? ☐ Yes ☐ No

(c) Are there any individuals currently employed by the institution, agency, or organization in a managerial, accounting, auditing, or similar capacity who were employed by the institution's, organization's, or agency's fiscal intermediary or carrier within the previous 12 months? (Title XVIII providers only) ☐ Yes ☐ No

III. (a) List names, addresses for individuals, or the EIN for organizations having direct or indirect ownership or a controlling interest in the entity. (See instructions for definition of ownership and controlling interest attached page 10.) List any additional names and addresses under "Remarks" on Page 11-2. If more than one individual is reported and any of these persons are related to each other, this must be reported under Remarks.

Name	Address	EIN

(b) Type of Entity: (ONLY ONE ENTITY MUST BE CIRCLED)

☐ Sole Proprietorship ☐ Partnership ☐ Corporation ☐ Unincorporated ☐ Associations ☐ Other_____

Please Note:
When Claiming "Corporation" Providers Must Complete And Return The Following Forms:

- Corporate Board Of Directors Resolution Form (Attached, Pg. 14) Must Be Completed With Signature And Notary Stamp Or Seal
- Certificate Of Incorporation Or Certificate Of Authority
- Letter Of Good Standing From The Texas State Comptroller's Office. It Is A Requirement Of H.B. 175. A Certificate Can Be Obtained By Contacting:

  State Comptroller's Office
  Tax Assistance Section
  Interstate WATS Telephone Number 1-800-252-5555
  Austin Telephone Number 1-512-463-4600

There Is No Charge For This Request. The Request May Be Made By Telephone And The Certificate Will Be Mailed To The Requester. Callers Must Have The Taxpayer's Name, Taxpayer Identification Number, And Charter Number Available At The Time Of The Request.
If Corporation Has A 501c Internal Revenue Exemption, Letter Of Good Standing Is Not Required. Please Indicate This By Signing Below:

Corporate Name _____ Name (Written/Typed) _____

Signature _____ Date _____

(c) If the disclosing entity is a corporation, list names, addresses of the Directors, and EINs for corporations in remarks.

REMARKS:

Check appropriate box for each of the following questions

(d) Are any owners of the disclosing entity also owners of other Medicare/Medicaid facilities? (Example, sole proprietor, partnership or members of Board of Directors.) If yes, list names, addresses of individuals, and provider numbers.

☐ Yes ☐ No

Name	Address	Provider Number

IV. (a) Has there been a change in ownership or control within the last year?
If yes, give date ☐ Yes ☐ No

(b) Do you anticipate any change of ownership or control within the year?
If yes, when? ☐ Yes ☐ No

(c) Do you anticipate filing for bankruptcy within the year?
If yes, when? ☐ Yes ☐ No

V. Is this facility operated by a management company, or leased in whole or part by another organization?
If yes, give date of change in operations ☐ Yes ☐ No

VI. Has there been a change in Administrator, Director of Nursing or Medical Director within the last year? ☐ Yes ☐ No

VII. (a) Is this facility chain affiliated? (If yes, list name, address of Corporation, and EIN) ☐ Yes ☐ No
Name EIN #

Address

(b) If the answer to Question VII.a. is "No", was the facility ever affiliated with a chain? ☐ Yes ☐ No
(If YES, list Name, Address of Corporation and EIN)
Name EIN #

Address

VIII. Have you increased your bed capacity by 10% or more or by 10 beds, whichever is greater, within the last 2 years? ☐ Yes ☐ No

If yes, give year of change_____ Current beds_____ Prior beds _____

Whoever Knowingly And Willfully Makes Or Causes To Be Made A False Statement Or Representation Of This Statement, May Be Prosecuted Under Applicable Federal Or State Laws. In Addition, Knowingly And Willfully Failing To Fully And Accurately Disclose The Information Requested May Result In Denial Of A Request To Participate Or Where The Entity Already Participates, A Termination Of Its Agreement Or Contract With The State Agency Or The Secretary, As Appropriate.

Name of Authorized Representative (Typed)	Title

Signature	Date

Form **W-9**
(Rev. December 1996)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

Give form to the requester. Do NOT send to the IRS.

Please print or type

Name (If a joint account or you changed your name, see Specific Instructions on page 2.)

Business name, if different from above (See Specific Instructions on page 2.)

Check appropriate box: ☐ Individual/Sole proprietor ☐ Corporation ☐ Partnership ☐ Other ▶

Address (number, street, and apt. or suite no.)

Requester's name and address (optional)

City, state, and ZIP code

(See specific instructions on page 2.)

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. For individuals, this is your social security number (SSN). However, if you are a resident alien OR a sole proprietor, see the instructions on page 2. For other entities, it is your employer identification number (EIN). If you do not have a number, see How To Get a TIN on page 2.

Note: If the account is in more than one name, see the chart on page 2 for guidelines on whose number to enter.

Social security number

OR

Employer identification number

Part II For Payees Exempt From Backup Withholding (See the instructions on page 2.)

▶

Part III Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me), and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding.

Certification Instructions. — You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the Certification, but you must provide your correct TIN. (See the instructions on page 2.)

Sign Here — Signature ▶ Date ▶

Purpose of Form. — A person who is required to file an information return with the IRS must get your correct taxpayer identification number (TIN) to report, for example, income paid to you, real estate transactions, mortgage interest you paid, acquisition or abandonment of secured property, cancellation of debt, or contributions you made to an IRA.

Use Form W-9 to give your correct TIN to the person requesting it (the requester) and, when applicable, to:

1. Certify the TIN you are giving is correct (or you are waiting for a number to be issued),
2. Certify you are not subject to backup withholding, or
3. Claim exemption from backup withholding if you are an exempt payee.

Note: If a requester gives you a form other than a W-9 to request your TIN, you must use the requester's form if it is substantially similar to this Form W-9.

What is Backup Withholding? — Persons making certain payments to you must withhold and pay to the IRS 31% of such payments under certain conditions. This is called "backup withholding." Payments that may be subject to backup withholding include interest, dividends, broker and barter exchange transactions, rents, royalties, nonemployee pay, and certain payments from fishing boat operators. Real estate transactions are not subject to backup withholding.

If you give the requester your correct TIN, make the proper certifications, and report all your taxable interest and dividends on your tax return, payments you receive will not be subject to backup withholding. Payments you receive will be subject to backup withholding if:

1. You do not furnish your TIN to the requester, or
2. The IRS tells the requester that you furnished an incorrect TIN, or
3. The IRS tells you that you are subject to backup withholding because you did not report all your interest and dividends on your tax return (for reportable interest and dividends only), or
4. You do not certify to the requester that you are not subject to backup withholding under 3 above (for reportable interest and dividend accounts opened after 1983 only), or
5. You do not certify your TIN when required. See the Part III instructions on page 2 for details.

Certain payees and payments are exempt from backup withholding. See the Part II instructions and the separate Instructions for the Requester of Form W-9.

Penalties

Failure To Furnish TIN. — If you fail to furnish your correct TIN to a requester, you are subject to a penalty of $50 for each such failure unless your failure is due to reasonable cause and not to willful neglect.

Civil Penalty for False Information With Respect to Withholding. — If you make a false statement with no reasonable basis that results in no backup withholding, you are subject to a $500 penalty.

Criminal Penalty for Falsifying Information. — Willfully falsifying certifications or affirmations may subject you to criminal penalties including fines and/or imprisonment.

Misuse of TINs. — If the requester discloses or uses TINs in violation of Federal law, the requester may be subject to civil and criminal penalties.

DA

Form **W-9** (Rev. 12-96)

STF REG1322.1

Specific Instructions

Name. — If you are an individual, you must generally enter the name shown on your social security card. However, if you have changed your last name, for instance, due to marriage, without informing the Social Security Administration of the name change, enter your first name, the last name shown on your social security card, and your new last name.

If the account is in joint names, list first and then circle the name of the person or entity whose number you enter in Part I of the form.

Sole Proprietor. — You must enter your **individual** name as shown on your social security card. You may enter your business, trade, or "doing business as" name on the **business name** line.

Other Entities. — Enter the business name as shown on required Federal tax documents. This name should match the name shown on the charter or other legal document creating the entity. You may enter any business, trade, or "doing business as" name on the business name line.

Part I — Taxpayer Identification Number (TIN)

You must enter your TIN in the appropriate box. If you are a resident alien and you do not have and are not eligible to get an SSN, your TIN is your IRS individual taxpayer identification number (ITIN). Enter it in the social security number box. If you do not have an ITIN, see **How To Get a TIN** below.

If you are a sole proprietor and you have an EIN, you may enter either your SSN or EIN. However, using your EIN may result in unnecessary notices to the requester.

Note: *See the chart on this page for further clarification of name and TIN combinations.*

How To Get a TIN. — If you do not have a TIN, apply for one immediately. To apply for an SSN, get **Form SS-5** from your local Social Security Administration office. Get **Form W-7** to apply for an ITIN or **Form SS-4** to apply for an EIN. You can get Forms W-7 and SS-4 from the IRS by calling 1-800-TAX-FORM (1-800-829-3676).

If you do not have a TIN, write "Applied For" in the space for the TIN, sign and date the form, and give it to the requester. For interest and dividend payments, and certain payments made with respect to readily tradable instruments, you will generally have 60 days to get a TIN and give it to the requester. Other payments are subject to backup withholding.

Note: *Writing "Applied For" means that you have already applied for a TIN OR that you intend to apply for one soon.*

Part II — For Payees Exempt From Backup Withholding

Individuals (including sole proprietors) are **not** exempt from backup withholding. Corporations are exempt from backup withholding for certain payments, such as interest and dividends. For more information on exempt payees, see the separate Instructions for the Requester of Form W-9.

If you are exempt from backup withholding, you should still complete this form to avoid possible erroneous backup withholding. Enter your correct TIN in Part I, write "Exempt" in Part II, and sign and date the form.

If you are a nonresident alien or a foreign entity not subject to backup withholding, give the requester a completed **Form W-8**, Certificate of Foreign Status.

Part III — Certification

For a joint account, only the person whose TIN is shown in Part I should sign (when required).

1. Interest, Dividend, and Barter Exchange Accounts Opened Before 1984 and Broker Accounts Considered Active During 1983. You must give your correct TIN, but you do not have to sign the certification.

2. Interest, Dividend, Broker, and Barter Exchange Accounts Opened After 1983 and Broker Accounts Considered Inactive During 1983. You must sign the certification or backup withholding will apply. If you are subject to backup withholding and you are merely providing your correct TIN to the requester, you must cross out item 2 in the certification before signing the form.

3. Real Estate Transactions. You must sign the certification. You may cross out item 2 of the certification.

4. Other Payments. You must give your correct TIN, but you do not have to sign the certification unless you have been notified that you have previously given an incorrect TIN. "Other payments" include payments made in the course of the requester's trade or business for rents, royalties, goods (other than bills for merchandise), medical and health care services (including payments to corporations), payments to a nonemployee for services (including attorney and accounting fees), and payments to certain fishing boat crew members.

5. Mortgage Interest Paid by You, Acquisition or Abandonment of Secured Property, Cancellation of Debt, or IRA Contributions. You must give your correct TIN, but you do not have to sign the certification.

Privacy Act Notice

Section 6109 of the Internal Revenue Code requires you to give your correct TIN to persons who must file information returns with the IRS to report interest, dividends, and certain other income paid to you, mortgage interest you paid, the acquisition or abandonment of secured property, cancellation of debt, or contributions you made to an IRA. The IRS uses the numbers for identification purposes and to help verify the accuracy of your tax return. The IRS may also provide this information to the Department of Justice for civil and criminal litigation and to cities, states, and the District of Columbia to carry out their tax laws.

You must provide your TIN whether or not you are required to file a tax return. Payers must generally withhold 31% of taxable interest, dividend, and certain other payments to a payee who does not give a TIN to a payer. Certain penalties may also apply.

What Name and Number To Give the Requester

For this type of account:	Give name and SSN of:
1. Individual	The individual
2. Two or more individuals (joint account)	The actual owner of the account or, if combined funds, the first individual on the account[1]
3. Custodian account of a minor (Uniform Gift to Minors Act)	The minor[2]
4. a. The usual revocable savings trust (grantor is also trustee)	The grantor-trustee[1]
b. So-called trust account that is not a legal or valid trust under state law	The actual owner[1]
5. Sole proprietorship	The owner[3]
For this type of account:	**Give name and EIN of:**
6. Sole proprietorship	The owner[3]
7. A valid trust, estate, or pension trust	Legal entity[4]
8. Corporate	The corporation
9. Association, club, religious, charitable, educational, or other tax-exempt organization	The organization
10. Partnership	The partnership
11. A broker or registered nominee	The broker or nominee
12. Account with the Department of Agriculture in the name of a public entity (such as a state or local government, school district, or prison) that receives agricultural program payments	The public entity

[1] List first and circle the name of the person whose number you furnish. If only one person on a joint account has an SSN, that person's number must be furnished.

[2] Circle the minor's name and furnish the minor's SSN.

[3] You must show your individual name, but you may also enter your business or "doing business as" name. You may use either your SSN or EIN (if you have one).

[4] List first and circle the name of the legal trust, estate, or pension trust. (Do not furnish the TIN of the personal representative or trustee unless the legal entity itself is not designated in the account title.)

Note: *If no name is circled when more than one name is listed, the number will be considered to be that of the first name listed.*

THE FOLLOWING FORM IS FOR CORPORATIONS ONLY,
AS INDICATED ON PAGE 11-1, QUESTION III (b)

Corporate Board Of Directors Resolution

State Of _____

County Of _____

On The _____ Day Of _____, 19_____, At A Meeting Of The

Board Of Directors Of _____, A Corporation, Held In The

City Of _____, In_____ County, With A Quorum Of The Directors Present, The Following Business Was Conducted:

It Was Duly Moved And Seconded That The Following Resolution Be Adopted:

Be It Resolved That The Board Of Directors Of The Above Corporation Do Hereby Authorize

_____

And His/Her Successors In Office To Negotiate, On Terms And Conditions That He/She May Deem Advisable, A Contract Or Contracts With The Texas Department Of Health, And To Execute Said Contract Or Contracts On Behalf Of The Corporation, And Further We Do Hereby Give Him/Her The Power And Authority To Do All Things Necessary To Implement, Maintain, Amend, Or Renew Said Contract.

The Above Resolution Was Passed By A Majority Of Those Present And Voting In Accordance With The By-Laws And Articles Of Incorporation.

I Certify That The Above Constitutes A True And Correct Copy Of A Part Of The Minutes Of A Meeting Of The

Board Of Directors Of _____

Held On The _____ Day Of _____, 19_____.

_____

Signature Of Secretary

Subscribed And Sworn Before Me, _____, A Notary Public For

The County Of _____, On The _____ Day Of _____, 19____.

Notary Stamp/Seal

Notary Public, County Of _____

State Of _____

REQUIRED FORM:
Audit Information Form is to be filled out by facilities, such as hospitals, home health, rural health, FQHC, and renal dialysis.

Medicaid Audit Information

HOSPITALS,
HOSPITAL-AFFILIATED AMBULATORY SURGICAL CENTERS,
HOME HEALTH,
FREESTANDING PSYCHIATRIC FACILITY,
CHRONIC RENAL DISEASE,
TEXAS DEPARTMENT OF MENTAL HEALTH AND MENTAL RETARDATION (MHMR),
FQ, FEDERALLY QUALIFIED HEALTH CENTER, AND
COMPREHENSIVE OUTPATIENT REHABILITATION FACILITY

Cost reports, for applicable providers, are to be filed according to Medicare regulations. Please provide us with the following information.

Medicaid Provider No. _____
(To be filled out by NHIC)

Provider Name: _____

Current Fiscal Year End: _____

Medicare Intermediary: _____
(Name and address of
where you send your _____
Medicare cost report)
_____

Phone:_____

Contact For Cost Report
Information: Name: _____
(At facility)
Phone: _____

REQUIRED FORM:
Dental Specialty Form is to be filled out by dental providers only.

Dental Specialty Form

Dental Providers Only

Please designate one specialty:

- ☐ Endodontia
- ☐ General Dentistry
- ☐ Oral & Maxillofacial Surgery
- ☐ Orthodontia
- ☐ Pediatric Dentistry
- ☐ Periodontia
- ☐ Public Health Dentistry
- ☐ Other

Check any box that applies certification by the Texas board of dental examiners for anesthesia or sedation permits for:

- ☐ Level One - Nitrous Use
- ☐ Level Two - Parental
- ☐ Level Three - General

Provider Name Printed _____ Date _____

Provider Name Signed _____

OPTIONAL RE-ENROLLMENT FORMS FOR:

Electronic Claims Submission (ECS) Notification:

Please be advised that signing the provider agreement automatically enrolls providers for Electronic Claims Submission of Medicaid claims only.

For more information regarding ECS, please contact Provider Automation at 888-863-3638.

ATTENTION: If you are NOT a current electronic biller and/or a new enrolling provider and wish to bill electronically, you must contact Provider Automation at 888-863-3638 in order to activate your electronic billing capability.

ELECTRONIC FUNDS TRANSFER (EFT) INFORMATION

Electronic Funds Transfer (EFT) is a payment method to deposit funds for claims approved for payment directly into a provider's bank account. These funds can be credited to either checking or savings accounts, *provided* the bank selected accepts Automated Clearing House (ACH) transactions. EFT also avoids the risks associated with mailing and handling paper checks, *ensuring funds are directly deposited into a specified account.*

The following items are specific to EFT:

- EFT funds are available to providers when banks open on Wednesday mornings (Thursday in the event of a bank holiday).
- Applications are processed within five (5) workdays of receipt.
- Prenotification to your bank takes place on the cycle following the application processing.
- Ten (10) days after prenotification, future deposits are received electronically.
- The Remittance and Status (R&S) Report furnishes the details of individual credits made to the provider's account during the weekly cycle.
- Specific deposits and associated R&S reports are cross-referenced by both provider number and R&S number.
- The availability of R&S reports is unaffected by EFT and they continue to arrive in the same manner and timeframe as currently received.

NHIC must provide the following notification according to ACH guidelines:

> "Most receiving depository financial institutions receive credit entries on the day before the effective date, and these funds are routinely made available to their depositors as of the opening of business on the effective date. The effective date for EFT under the Texas Medicaid Program, and the Chronically Ill and Disabled Children (CIDC), is Wednesday (or Thursday) of each week.
>
> However, due to geographic factors, some receiving depository financial institutions do not receive their credit entries until the morning of the effective day and the internal records of these financial institutions will not be updated. As a result, tellers, bookkeepers or automated teller machines (ATMs) may not be aware of the deposit and the customer's withdrawal request may be refused. When this occurs, the customer or company should discuss the situation with the ACH coordinator of their institution who, in turn should work out the best way to serve their customer's needs.
>
> In all cases, credits received should be posted to the customer's account on the effective date and thus be made available to cover checks or debits that are presented for payment on the effective date."

To enroll in the EFT program, complete the attached Electronic Funds Transfer Authorization Agreement. *A voided check or deposit slip must be returned with the agreement to the NHIC address indicated on the form*. Please contact the TexMedNet Help Desk at 1-888-863-3638 if you need assistance.

Electronic Funds Transfer (EFT)
Authorization Agreement

NOTE: Complete all sections below and *attach a voided check or a photocopy of your deposit slip*.
Enter ONE provider number per form.

Type Of Authorization _____NEW _____CHANGE

Provider Name	**Nine-Digit Billing Provider No.**
Provider Accounting Address	**Provider Phone No.**

Bank Name	**ABA/Transit No.**
Bank Phone No.	**Account No.**
Bank Address	**Type Account (check one)**
	Checking
	Savings

I (we) hereby authorize National Heritage Insurance Company (NHIC) to present credit entries into the bank account referenced above and the depository named above to credit the same to such account. I (we) understand that I (we) am responsible for the validity of the information on this form. If the company erroneously deposits funds into my (our) account, I (we) authorize the company to initiate the necessary debit entries, not to exceed the total of the original amount credited for the current pay period.

I (we) agree to comply with all certification requirements of the applicable program regulations, rules, handbooks, bulletins, standards, and guidelines published by the Texas Department of Health (TDH) or its health insuring contractor. I (we) understand that payment claims will be from federal and state funds, and that any falsification, or concealment of a material fact, may be prosecuted under federal and state laws.

I (we) will continue to maintain the confidentiality of records and other information relating to recipients in accordance with applicable state and federal laws, rules, and regulations.

_____ _____
Authorized Signature Date

_____ _____
Title Internet Address (if applicable)

_____ _____
Contact Name Phone

Please return this form to:

NHIC
Attn: Provider Enrollment
11044 Research Blvd., Bldg. C
Austin TX 78759-5239

Input By _____ Date _____

Electronic Remittance and Status (ER&S) Agreement

NOTE: If the PROVIDER is dialing the BBS to download the ER&S, fill out BLOCK 1 and BLOCK 3. In BLOCK 3, check Option 1.
If a BUSINESS ORGANIZATION OTHER THAN THE PROVIDER is dialing the BBS to download the ER&S, fill out BLOCK 1, BLOCK 2 and BLOCK 3. In BLOCK 3, check Option 2.

BLOCK 1

Provider Name	Provider Phone No.	Provider Tax ID No.
Provider Contact Name (If other than provider)	Provider Contact Phone Number	
Provider's Physical Address	Medicaid Nine-Digit Billing Provider Number(s)	

Fill in Block 2 ONLY if the information is different than Block 1:

BLOCK 2

Name of Business Organization to Receive ER&S	Business Organization Phone Number
Business Organization Contact Name	Business Organization Contact Phone Number
Business Organization Address	Business Organization Tax ID Number

Note: Indicate location to receive Remittance and Status (R&S) information (check box 1 or 2):
Indicate format preference for receiving Remittance and Status (R&S) information (check box 3 or 4):

BLOCK 3

	For NHIC use only
___ 1. Electronic R&S sent to provider's electronic mailbox with no change to the paper R&S destination.	M N Q 1 _ _
___ 2. Electronic R&S sent to business organization's (identified in block 2 of this form) electronic mailbox with no change to the paper R&S destination.	M N Q 1 _ 1
___ 3. Electronic R&S to be received using NHIC software (TDH Connect), OR	TXMEDNET
___ 4. Electronic R&S to be received using anything other than NHIC software (TDH Connect).	TXSMPROV

I (we) request to receive Electronic Remittance and Status information and authorize the information to be deposited in the electronic mailbox as indicated above. I (we) accept financial responsibility for costs associated with receipt of Electronic R&S information.

I (we) understand that paper-formatted R&S information will continue to be sent to my (our) accounting address as maintained at NHIC until I (we) submit an Electronic R&S Certification Request form.

I (we) will continue to maintain the confidentiality of records and other information relating to recipients in accordance with applicable state and federal laws, rules, and regulations.

Provider Signature _____ Date _____

Title _____ Internet Address (if applicable) _____

Input By_____Input Date_____
ECMS Mailbox ID _____

Appendix A

Advanced Practice Nurse
To enroll in the Texas Medicaid Program, an advanced practice nurse (APN) must be licensed as a registered nurse and be recognized as an APN by the Board of Nurse Examiners for the State of Texas. All APNs are enrolled within the categories of practice as determined by the Board of Nurse Examiners.

Ambulance/Air Ambulance
To enroll in the Texas Medicaid Program, ambulance providers must: 1) operate according to the laws, regulations, and guidelines governing ambulance services under Medicare Part B; 2) equip and operate under the appropriate rules, licensing, and regulations of the state in which they operate; 3) acquire a license from TDH approving equipment and training levels of the crew; and 4) enroll in Medicare. A hospital-operated ambulance provider must be enrolled as an ambulance provider and submit claims using the ambulance provider number, not the hospital provider number.

Ambulatory Surgical Center
To enroll in the Texas Medicaid Program, Ambulatory Surgical Centers (ASCs) must: meet and comply with applicable state and federal laws and provisions of the state plan under Title XIX of the Social Security Act for Medical Assistance, and be enrolled in Medicare. Out-of-state ASCs that are Medicare-certified as an ASC in the state where they are located and provide services to a Texas Medicaid client, may be entitled to participate in the Texas Medicaid Program.

Audiologist
To enroll in the Texas Medicaid Program, hearing aid professionals (physicians, audiologists, and fitters and dispensers) who provide hearing evaluations or fitting and dispensing services must be licensed by the licensing board of their profession to practice in the state where the service was performed and be enrolled as a Medicare provider. Additionally, audiologists must also be currently certified by the American Speech, Language, and Hearing Association or meet the Association's equivalency requirements.

Birthing Center
To enroll in the Texas Medicaid Program, a birthing center must be licensed by TDH. Texas Medicaid only reimburses birthing center services that provide a level of service equal to the professional skills of a physician or certified nurse-midwife (CNM) who acts as the birth attendant. A birthing center is defined as a facility or institution where a woman is scheduled to give birth following an uncomplicated (low-risk) pregnancy. This term does not include a hospital, ambulatory surgical center, nursing facility, or residence of the woman giving birth.

Catherization Lab
To enroll in the Texas Medicaid Program, a catherization lab must be Medicare-certified.

Certified Nurse Midwife
To enroll in the Texas Medicaid Program, a certified nurse-midwife (CNM) must be a licensed registered nurse who is recognized by the Board of Nurse Examiners for the State of Texas as an advanced practice nurse in nurse-midwifery and certified by the American College of Nurse-Midwives. Medicare enrollment is a prerequisite for enrollment as a Medicaid provider.

Certified Registered Nurse Anesthetist
To enroll in the Texas Medicaid Program, a certified registered nurse anesthetist (CRNA) must be a registered nurse approved as an advanced practice nurse by the state in which they practice and be currently certified by either the Council on Certification of Nurse Anesthetists or the Council on Recertification of Nurse Anesthetists. Medicare enrollment is a prerequisite for enrollment as a Medicaid provider.

Chemical Dependency Treatment Facility
Chemical dependency treatment facilities licensed by the Texas Commission on Alcohol and Drug Abuse (TCADA) are eligible to enroll in the Texas Medicaid Program. Chemical dependency treatment facility services are those facility services determined by a qualified credentialed professional, as defined by the Texas Commission on Alcohol and Drug Abuse (TCADA) Chemical Dependency Treatment Facility Licensure Standards, to be reasonable and necessary for the care of a person under 21 years of age who is chemically dependent.

Chiropractor
To enroll in the Texas Medicaid Program, a doctor of chiropractic (DC) medicine must be licensed by the Texas Board of Chiropractic Examiners and enrolled as a Medicare provider.

Comprehensive Health Centers
To enroll in the Texas Medicaid Program to provide medical services, physicians (MD and DO) and doctors (DMD, DDS, OD, DPM, and DC) must be licensed by the licensing authority of their profession to practice in the state where the service is performed at the time services are provided. All physicians except pediatricians and physicians doing only THSteps medical screens must be enrolled in Medicare before Medicaid enrollment. NHIC may waive the Medicare enrollment prerequisite for pediatricians or physicians whose type of practice and service may never be billed to Medicare.

Comprehensive Outpatient Rehab Facility
To enroll in the Texas Medicaid Program, a Comprehensive Outpatient Rehab Facility (CORF) must be Medicare-certified. CORFs are public or private institutions primarily engaged in providing, under medical direction, diagnostic, therapeutic, and restorative services to outpatients, and are required to meet specified conditions of participation.

Dental
To become a provider of THSteps or ICF-MR dental services, a dentist must be licensed by the Texas State Board of Dental Examiners and complete an enrollment application with NHIC. A dentist must complete an enrollment application for each separate practice location and will receive a unique nine-digit Medicaid provider identification number with one of the following prefixes for each practice location: DENT – Medicaid/THSteps dental provider, DENTA – Provider 1st office, DENTB – Provider 2nd office, DENTG – Group dental, D8P – Individual provider within a group, D0D – DDS as limited physician (HCFA-1500), D000 – Medicare provider (HCFA-1500), Z000 – Medicare group provider (HCFA-1500), P08 – Medicare individual in group, FQ – Federally qualified health center (FQHC). Dentists providing services under the D0D provision must also apply for and receive a Medicare provider identification number (D000, Z000, or P08 prefix).

Dietitian
Independently practicing licensed dietitians may enroll in Texas Medicaid to provide services to THSteps-CCP Program clients. Providers of nutritional services and counseling must be licensed by the Texas State Board of Examiners of Dietitians in accordance with the *Licensed Dietitians Act,* Article 4512h.

Durable Medical Equipment
To be eligible to participate in the THSteps-Comprehensive Care Program (CCP), providers of durable medical equipment (DME) must be enrolled in TDH's Vendor Drug Program (for payment of prescription drugs) or be enrolled in Medicare (Palmetto). Enrolled providers of DME or expendable medical supplies are issued a DMEH provider number that is specific to home health services. These providers must be Medicare-certified as a DME/medical supplier. Providers of customized or nonbasic medical equipment must also be enrolled as a Medicare DME provider. Orthotic and prosthetic providers are also enrolled as a Medicare DME provider.

Early Childhood Intervention
To enroll in the Texas Medicaid Program, an ECI provider must comply with all applicable federal, state, local laws, and regulations regarding the services provided. The ECI provider must contact the Texas ECI Program at 512-424-6811. After meeting the case management criteria of the Texas ECI Program, providers must request a Medicaid application from NHIC Provider Enrollment.

Family Planning Agency
Family planning services are preventive health, medical, counseling, and educational services that assist individuals in managing their fertility and achieving optimal reproductive and general health. To enroll in the Texas Medicaid Program, family planning agencies must ensure that all services are furnished by, prescribed by, or provided under the direction of a licensed physician and have a medical director who is a physician currently licensed to practice medicine in Texas. Agencies must have an established record of performance in the provision of both medical and educational/counseling family planning services as verified through client records, established clinic hours, and clinic site locations; provide family planning services in accordance with TDH standards of client care for family planning agencies; and be approved for family planning services by the TDH Family Planning Program. Physicians who wish to provide Medicaid Obstetric and Gynecologic (OB-GYN) services are allowed to bypass Medicare enrollment and obtain a Medicaid-only provider number for OB-GYN services regardless of provider specialty. Similarly, federally qualified health centers do not need to apply for a separate physician or agency number. Family planning services are payable under the existing FQHC provider number using family planning procedure codes.

Federally Qualified Health Center
To enroll in the Texas Medicaid Program, a Federally Qualified Health Center (FQHC) must be receiving a grant under Section 329, 330, or 340 of the Public Health Service Act or designated by the U.S. Department of Health and Human Services to have met the requirements to receive this grant. FQHCs and their satellites are required to enroll in Medicare to be eligible for Medicaid enrollment. FQHC "look-alikes" are not required to enroll in Medicare but may elect to do so to receive reimbursement for crossovers. A copy of the Public Health Service issued notice of grant award reflecting the project period and the current budget period must be submitted with the enrollment application. A current notice of grant award must be submitted to the NHIC Provider Enrollment Department annually. Centers are required to notify NHIC of all satellite centers that are affiliated with the parent FQHC and their actual physical addresses. All FQHC satellite centers billing Medicaid for FQHC services must also be approved by the Public Health Service. For accounting purposes, centers may elect to enroll the Public Health Service-approved satellites using an FQS provider number that ties back to the parent FQHC provider number and tax ID. This procedure allows for the parent FQHC to have one provider agreement as well as one cost report combining all costs from all approved satellites and the parent FQHC. If an approved satellite chooses to bill the Texas Medicaid Program directly, the center must have a separate provider number from the parent FQHC and will be required to file a separate cost report.

Federally Qualified Look-Alike
To enroll in the Texas Medicaid Program, a Federally Qualified Health Center (FQHC) must be receiving a grant under Section 329, 330, or 340 of the Public Health Service Act or designated by the U.S. Department of Health and Human Services to have met the requirements to receive this grant. FQHCs and their satellites are required to enroll in Medicare to be eligible for Medicaid enrollment. FQHC "look-alikes" are not required to enroll in Medicare but may elect to do so to receive reimbursement for crossovers. A copy of the Public Health Service issued notice of grant award reflecting the project period and the current budget period must be submitted with the enrollment application. A current notice of grant award must be submitted to the NHIC Provider Enrollment Department annually. Centers are required to notify NHIC of all satellite centers that are affiliated with the parent FQHC and their actual physical addresses. All FQHC satellite centers billing Medicaid for FQHC services must also be approved by the Public Health Service. For accounting purposes, centers may elect to enroll the Public Health Service-approved satellites using an FQS provider number that ties back to the parent FQHC provider number and tax ID. This procedure allows for the parent FQHC to have one provider agreement as well as one cost report combining all costs from all approved satellites and the parent FQHC. If an approved satellite chooses to bill the Texas Medicaid Program directly, the center must have a separate provider number from the parent FQHC and will be required to file a separate cost report.

Federally Qualified Satellite
To enroll in the Texas Medicaid Program, a Federally Qualified Health Center (FQHC) must be receiving a grant under Section 329, 330, or 340 of the Public Health Service Act or designated by the U.S. Department of Health and Human Services to have met the requirements to receive this grant. FQHCs and their satellites are required to enroll in Medicare to be eligible for Medicaid enrollment. FQHC "look-alikes" are not required to enroll in Medicare but may elect to do so to receive reimbursement for crossovers. A copy of the Public Health Service issued notice of grant award reflecting the project period and the current budget period must be submitted with the enrollment application. A current notice of grant award must be submitted to the NHIC Provider Enrollment Department annually. Centers are required to notify NHIC of all satellite centers that are affiliated with the parent FQHC and their actual physical addresses. All FQHC satellite centers billing Medicaid for FQHC services must also be approved by the Public Health Service. For accounting purposes, centers may elect to enroll the Public Health Service-approved satellites using an FQS provider number that ties back to the parent FQHC provider number and tax ID. This procedure allows for the parent FQHC to have one provider agreement as well as one cost report combining all costs from all approved satellites and the parent FQHC. If an approved satellite chooses to bill the Texas Medicaid Program directly, the center must have a separate provider number from the parent FQHC and will be required to file a separate cost report.

Freestanding Psychiatric Facility
To be eligible to participate in the THSteps-Comprehensive Care Program (CCP), a psychiatric hospital/facility must be accredited by the Joint Commission on Accreditation of Health Care Organizations (JCAHO), have a valid provider agreement with TDH, and have completed the NHIC enrollment process. Facilities certified by Medicare must also meet the JCAHO accreditation requirements. Freestanding psychiatric hospitals enrolled in Medicare may also receive payment for Medicare deductible and coinsurance amounts with the exception of clients ages 22-64.

Freestanding Rehabilitation Facility
To be eligible to participate in the THSteps-Comprehensive Care Program (CCP), a freestanding rehabilitation hospital must be certified by Medicare, have a valid Provider Agreement with the TDH, and have completed the NHIC enrollment process. The Texas Medicaid Program enrolls and reimburses freestanding rehabilitation hospitals for CCP services and Medicare deductible/coinsurance. The information in this section is applicable to CCP services only.

Genetics
Only full-service genetic providers may enroll in the Texas Medicaid Program. Before enrolling, the provider must contract with TDH for the provision of genetic services. Basic contract requirements are as follows. 1) The provider's medical director must be a clinical geneticist (MD or DO) who is board eligible/certified by the American Board of Medical Geneticists (ABMG). The physician must oversee the delivery and content of all medical services. 2) The provider must use a team of professionals to provide genetic evaluative, diagnostic, and counseling services. The team rendering the services must consist of at least the following professional staff. 3) The clinical geneticist (MD or DO) and at least one of the following: nurse, genetic associate, social worker, medical geneticist, or genetic counselor. Administrative personnel and support staff may also be involved. Additionally, each genetic professional providing clinical services must obtain a performing provider number from NHIC. For more contracting information, contact: TDH Genetic Screening and Case Management Division, 1100 West 49th Street, Austin TX 78756-3199, 512-458-7700.

Hearing
To enroll in the Texas Medicaid Program, hearing professionals (physicians, audiologists, and fitters and dispensers) who provide hearing evaluations or fitting and dispensing services must be licensed by the licensing board of their profession to practice in the state where the service was performed and be enrolled as a Medicare provider. Additionally, audiologists must also be currently certified by the American Speech, Language, and Hearing Association or meet the Association's equivalency requirements.

Home Health
To enroll in the Texas Title XIX Medicaid Program home health services providers must be certified by Medicare and complete the Texas Medicaid enrollment application. Enrolled providers of DME and/or expendable medical supplies will be issued a DMEH provider number that is specific to home health services.

Hospital – In State/Out of State
To be eligible to participate in the Texas Medicaid Program, a hospital must be certified by Medicare, have a valid provider agreement with TDH, and have completed the NHIC enrollment process.

Hospital Ambulatory Surgical Center
Hospitals certified and enrolled in the Texas Medicaid Program are assigned a nine-digit provider number (HASC) exclusively for billing day surgeries.

Hospital – Military
To enroll in the Texas Medicaid Program, a military hospital must be certified by Medicare, have a valid provider agreement with TDH, and have completed the NHIC enrollment process. Veteran's Administration (VA) hospitals are eligible to receive Texas Medicaid payment only on claims that have crossed over from Medicare.Certified Registered Nurse Anesthetist Services (CRNA). To enroll in the Texas Medicaid Program, a certified registered nurse anesthetist (CRNA) must be a registered nurse approved as an advanced practice nurse by the state in which they practice and be currently certified by either the Council on Certification of Nurse Anesthetists or the Council on Recertification of Nurse Anesthetists. Medicare enrollment is a prerequisite for enrollment as a Medicaid provider.

Hyperalimentation
To enroll in the Texas Medicaid Program, providers of in-home total parental hyperalimentation must be enrolled in Medicare (Palmetto) as in-home total parental hyperalimentation supplier providers.

Independent Laboratory
To enroll in the Texas Medicaid Program, the independent (freestanding) laboratory must: 1) be independent from a physician's office or hospital, 2) meet staff, equipment, and testing capability standards for certification by TDH, and 3) have Medicare certification.

Licensed Professional Counselor
To enroll in the Texas Medicaid Program, independently or as a group of practicing licensed professional counselors (LPCs), you must be licensed by the Texas Board of Examiners of Professional Counselors. LPCs are covered as Medicaid-only providers; therefore, enrollment in Medicare is not a requirement for enrollment in Medicaid. Practitioners holding a temporary license are not eligible to enroll in Medicaid.

Licensed Vocational Nurse
Licensed and Certified Home Health agencies may enroll to provide private duty nursing (PDN) under the Texas Medicaid THSteps Comprehensive Care Program. The license under which an agency provides CCP PDN must be Medicare-certified for reimbursement. Registered nurses and licensed vocational nurses may also enroll to provide private duty nursing under the Texas Medicaid THSteps - Comprehensive Care Program.

Maternity Service Clinic
To enroll in the Texas Medicaid Program, maternity service clinics (MSC) must ensure that the physician prescribing the services is employed by or has a contractual agreement/ formal arrangement with the clinic to assume professional responsibility for the services provided to clinic patients. To meet this requirement a physician must see the patient at least once, prescribe the type of care provided, and if the services are not limited by the prescription, periodically review the need for continued care. Medicare certification is not a prerequisite for MSC enrollment. An MSC must: 1) be a facility that is not an administrative, organizational, or financial part of a hospital; 2) be organized and operated to provide maternity services to outpatients; 3) comply with all applicable federal, state, and local laws and regulations; 4) an MSC wanting to bill and receive reimbursement for case management services to high-risk pregnant adolescents, women, and infants must meet the eligibility criteria specified in the Case Management for High-Risk Pregnant Women and Infants section.

MH Case Management/MR Case Management
To enroll in the Texas Medicaid Program, MH and MR providers must contact TDMHMR at 512-206-5708 to be approved. Local mental health/mental retardation (MH/MR) providers are eligible to apply for the following MH and MR services: Case management–Provider number begins with MH or MR.

MH Rehab
To enroll in the Texas Medicaid Program, MH and MR providers must contact TDMHMR at 512-206-5708 to be approved. Local mental health/mental retardation (MH/MR) providers are eligible to apply for Rehabilitative services (Provider number begins with MHR).

Occupational Therapist
TDH allows Medicaid enrollment of independently practicing licensed occupational therapists in the THSteps-Comprehensive Care Program (CCP). Some occupational therapy services are also available under Home Health.

Optician
To enroll in the Texas Medicaid Program, doctors of optometry must be licensed by the licensing board of their profession to practice in the state where the service was performed, at the time the service was performed, and be enrolled as Medicare Providers.

Optometrist
To enroll in the Texas Medicaid Program, doctors of optometry must be licensed by the licensing board of their profession to practice in the state where the service was performed, at the time the service was performed, and be enrolled as Medicare Providers.

Physical Therapist
To enroll in the Texas Medicaid Program, independently practicing licensed physical therapists must be enrolled in Medicare. The Medicare enrollment requirement is waived for therapists providing services only to THSteps-eligible clients who are under 21 and not receiving Medicare benefits. If you are currently enrolled with the Texas Medicaid Program or plan to provide regular acute care services to clients with Medicaid coverage, enrollment in the THSteps-Comprehensive Care Program (CCP) is not necessary. All non-CCP physical therapy services must be billed with your current Medicaid provider number.

Physician
To enroll in the Texas Medicaid Program to provide medical services, physicians (MD and DO) and doctors (DMD, DDS, OD, DPM, and DC) must be licensed by the licensing authority of their profession to practice in the state where the service is performed at the time services are provided. All physicians except pediatricians, OB-GYNs, and physicians doing only THSteps medical screens must be enrolled in Medicare before Medicaid enrollment. NHIC may waive the Medicare enrollment prerequisite for pediatricians or physicians whose type of practice and service may never be billed to Medicare.

Physiological Labs
To enroll in the Texas Medicaid Program, radiological and physiological laboratories and portable X-ray suppliers must be enrolled in Medicare. Both radiological and physiological laboratories must be directed by a physician.

Podiatrist
Podiatrists (DPM) must be Medicare-certified and enrolled as Medicaid providers are authorized to perform procedures on the ankle or foot as approved by the Texas Legislature under their licensure as a DPM when such procedures would also be reimbursable to a physician (MD or DO) under the Texas Medicaid Program.

Portable X-Ray
To enroll in the Texas Medicaid Program, radiological and physiological laboratories and portable X-ray suppliers must be enrolled in Medicare. Both radiological and physiological laboratories must be directed by a physician.

Psychologist
To enroll in the Texas Medicaid Program, an independently practicing psychologist must be licensed by the Texas State Board of Examiners of Psychologists and be enrolled as a Medicare provider.

Radiological Lab
To enroll in the Texas Medicaid Program, radiological and physiological laboratories and portable X-ray suppliers must be enrolled in Medicare. Both radiological and physiological laboratories must be directed by a physician.

Radiation Treatment Center
To enroll in the Texas Medicaid Program, Radiation Treatment Centers must be Medicare-certified and certified by TDH Bureau of Radiation Control.

Registered Nurse
Licensed and Certified Home Health agencies may enroll to provide private duty nursing (PDN) under the Texas Medicaid THSteps Comprehensive Care Program. The license under which an agency provides CCP PDN must be Medicare-certified for reimbursement. Independently enrolled registered nurses and licensed vocational nurses may also enroll to provide private duty nursing under the Texas Medicaid THSteps - Comprehensive Care.

Renal Dialysis Facility
To enroll in the Texas Medicaid Program, a renal dialysis facility must be Medicare-certified in the state that it is located to provide services. Facilities must also adhere to the appropriate rules, licensing, and regulations of the state where they operate.

Respiratory Care Practitioner
To enroll in the Texas Medicaid Program, a respiratory care practitioner (CRCP) must be certified by TDH to practice under Texas Civil Statutes, Article 4512L. As of January 1, 1988, the National Board for Respiratory Care Exam must be passed to be certified by TDH. Medicare certification is not a prerequisite for Medicaid enrollment.

Rural Health Clinic
To enroll in the Texas Medicaid Program and qualify for participation as a Title XIX rural health clinic (RHC), RHCs must be enrolled in Medicare.

SHARS – School/Nonschool
To enroll in the Texas Medicaid Program, school districts, school cooperatives, and individuals or entities must meet Medicaid-approved or recognized certification and licensing requirements. These requirements must be consistent with state and federal laws and regulations and are subject to approval by TDH.A qualified provider may be an institution, agency, person, or organization chosen by the parent who agrees in writing with TDH to:1) provide SHARS as listed in the individual educational plan (IEP); 2) provide SHARS in the least restrictive environment as set forth in the IEP; 3) maintain and submit all records and reports required by the school district to ensure compliance with the IEP.

Social Worker
To enroll in the Texas Medicaid Program independently or as a group, a licensed master social worker-advanced clinical practitioner (LMSW-ACP) must be licensed through the State Board of Social Work Examiners as an LMSW-ACP and be enrolled in Medicare **or** obtain a pediatric practice exemption through NHIC Provider Enrollment. Practitioners holding a temporary license are not eligible to enroll in Medicaid.

Speech Therapist
TDH allows enrollment of independently practicing licensed speech-language pathologists under the THSteps-Comprehensive Care Program (CCP). The Texas Medicaid Program enrolls and reimburses speech-language pathologists for CCP services only.

Targeted Case Management (PWI)
To enroll in the Texas Medicaid Program, the case management provider must apply to the Texas Department of Health's (TDH) Division of Genetic Screening and Case Management for approval. The provider must also meet the following criteria: 1) Be a health service provider for women of childbearing age and/or for children with evidence of referral relationships with preventive, primary, and tertiary caretakers, agencies, or centers within the nearest geographic area; 2) Participate in the case management system for women of childbearing age, infants, and children who are medically at risk or who have diagnosed high-risk conditions; 3) Participate in the regional case management system (for example, participate with area regional and local health departments, other area case management providers, and the Bureau of Children's Health) so that referral and tracking of the client occurs; 4) Have a case management system that is community-based as evidenced by outreach activities, home visits, community education, and use of qualified local health education programs; 5) Have a case management system that uses registered nurses, licensed social workers, and community service aides; 6) Have a case management system that reduces barriers to service by providing assistance in completing applications, ensuring the ability to make timely appointments, providing assistance with transportation, and so on; and 7) Comply with all Medicaid-required reporting requirements. For more information about provider qualifications, contact the Division of Genetics Screening and Case Management at 512-458-7111, ext. 2193. Upon approval by TDH, Medicaid enrollment applications from the NHIC Provider Enrollment Department are sent to providers.

TB Clinic
To enroll in the Texas Medicaid Program, the tuberculosis (TB) clinic must be: 1) A public entity operating under TDH tax identification number (TB regional clinic) or 1) A public entity operating under a non-TDH tax identification number (city/county/ local clinic) or 1) A non-hospital based entity for private providers and 2) A provider of TB-related clinic services must apply to the TDH Tuberculosis Elimination Division. For more information about provider qualifications, contact the Tuberculosis Elimination Division, Financial Services and Medicaid Unit at 512-458-7447.To receive a provider application form or provider supplement, send a request to the following address: Tuberculosis Elimination Division, ATTN: Financial Services and Medicaid Unit, 1100 West 49th Street, Austin TX 78756-3199.

Texas Commission for the Blind
The Texas Commission for the Blind (TCB) is eligible to enroll as a Medicaid provider of case management for blind and visually impaired clients (BVIC) under the age of 16.

THSteps New Medical Case Management Services
Effective January 1, 1998, Texas Medicaid will cover THSteps Medical Case Management services provided to THSteps clients by approved THSteps Medical Case Management providers. THSteps Medical Case Management services assists eligible Medicaid clients in gaining access to medically necessary and appropriate medical, social, educational, and other services. Providers who want to provide THSteps Medical Case Management Services must be enrolled in the Medicaid program with a new provider number. Registered nurses (with a Bachelors or advanced degree) and licensed social workers (with a Bachelors or advanced degree) with appropriate community/medical experience, may enroll to provide these services.

Texas Health Steps (THSteps) Medical
To enroll in the Texas Medicaid and THSteps Program, providers must be licensed physicians (MD, DO); health care providers of facilities (public or private) capable of performing the required medical checkup procedures under the direction of a physician; (such as regional and local health departments; family planning clinics; migrant health clinics; community-based hospitals and clinics; maternity clinics; rural health clinics; home health agencies; and school districts). Family and pediatric nurse practitioners may enroll independently as THSteps providers. Certified nurse midwives may be enrolled as providers of THSteps medical checkups for newborns, up to two months of age, and adolescent females. Women's health care nurse practitioners may be enrolled as providers of THSteps medical checkups for adolescent females and adult nurse practitioners may enroll as providers of THSteps checkups for people over age 14.

Vision Medical Supplier
To enroll in the Texas Medicaid Program, doctors of optometry must be licensed by the licensing board of their profession to practice in the state where the service was performed, at the time the service was performed, and be enrolled as Medicare (Palmetto) Providers.

Women, Infant & Children (WIC) (Immunization Only)
To be eligible as a qualified provider for presumptive eligibility determinations the following federal requirements must be met. The provider must be 1) an eligible Medicaid provider, 2) provide outpatient hospital services, rural health clinic services, or clinic services furnished by or under the direction of a physician without regard to whether the clinic itself is administered by a physician (includes family planning clinics) and 3) receive funds from or participate in the WIC program.

Final checklist:

 Fill out all required forms

 Provide original signatures

 Attach all required documents

 Make a copy for your records

Mail Application to:
National Heritage Insurance Company
Attn: Provider Enrollment
11044 Research Blvd., Bldg. C
Austin TX 78759-5239